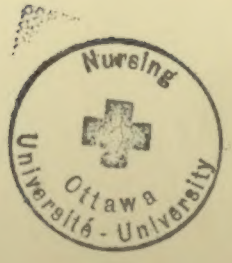
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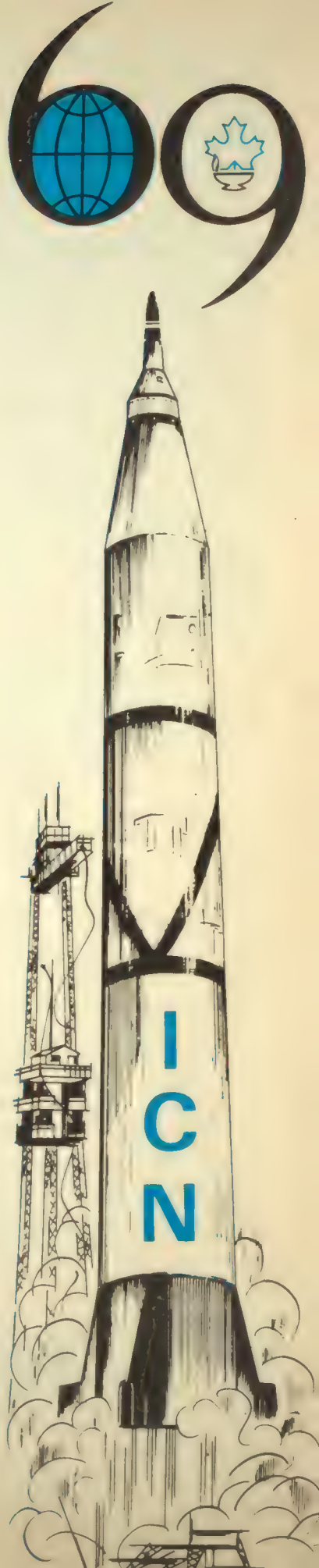
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In recent months, rumblings about "physicians' assistants" have been reverberating across the country. At a medical meeting in Toronto in September, a well-known medical educator spoke strongly in favor of setting up programs for physicians' assistants in Canada; an equally well-known medical educator stood up and disagreed with this proposal. The subject is being written about and discussed with fervor by doctors, most of whom have strong opinions one way or the other. Nurses should become interested in this controversy, mainly because the creation of this category of health worker would affect patient care as well as the nurses' role in providing this care.

The physicians' assistant role was created in the U.S.A. to bridge "the professional gap" between nursing and medicine and to relieve harassed doctors of much of their routine work. Does it logically follow that because this is good for the U.S. (and this is questionable) it is good for Canada?

The answer is "no." What is needed in Canada is more dialogue between the medical and nursing professions to find other ways of filling any present "gap."

It is the patient who will suffer if another category of health worker is added to the 50 existing ones. As the editor of the *American Journal of Nursing* pointed out in a July 1967 editorial on the subject of physicians' assistants, "The present multiplicity of professional health workers — each prepared to fulfill the specific functions of his euphemistically designated specialty — has already clouded and confused the scene beyond the comprehension of most health workers, not to mention the patient."

This month we present an article based on interviews of several doctors and nurses who hold opposite views about the value of the physicians' assistants (p.38). We agree with those who believe that there is no need for such workers in Canada.

As Dr. A.L. Chute, dean of medicine at University of Toronto, says in this interview: "I don't think there's any necessity for creating a new breed of cats." — **V.A.L.**

letters

Letters to the editor are welcome.
Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Widen your horizons

I would like to thank you for Joyce Irwin's article in the July issue "Widen Your Horizons."

The public library that I attend was very helpful and provided me with some wonderful summer reading. So far, I have read eight of the books mentioned in the article and found all of them very interesting. There are still a few mentioned in the article that I would like to read, especially the ones by Monica Dickens. – Esther V. Repol, Scarborough, Ont.

ICN Congress

I am writing to you in regard to the Congress of the International Council of Nurses to be held in Montreal in June 1969.

Five students from our hospital, myself among them, attended the Canadian Nurses' Association convention in Saskatoon last summer. All of us who attended now realize the value that these conventions hold both for students and graduate nurses.

We have the good fortune of being close at hand for the 1969 convention but would like to aid those who will have difficulty raising funds to attend.

Could you give me any information about student nurses who would like to attend the convention but cannot raise the funds? Our student council would like to supply transportation, lodging, and convention expenses for a student (or more than one, depending on costs) who could not otherwise come to Montreal. – Linda G. Carter, Montreal.

I understand that some nurses coming from abroad for the International Council of Nurses' Quadrennial Congress will have to find accommodation at the lowest available prices. A few of my friends and myself would be ready to offer rooms without charge to these colleagues. – Pierrette Delage, Montreal.

These letters have been brought to the attention of the Congress coordinator at CNA House. The editors.

We would appreciate receiving as soon as possible requests from any provincial associations or other groups who wish to schedule a private cocktail reception or dinner during the International Council of Nurses Congress to be held June 22 - 28, 1969 in Montreal.

We have blocked a number of salons in the Queen Elizabeth and Bonaventure Hotels, but cannot hold these rooms too much longer if we do not receive specific requests for reservations.

Please write: Convention Division, Panex Inc., Place Bonaventure, Montreal 3. – (Mrs.) Laila Chisnell, Congress Coordinator, Montreal.

Office Nurse

As a practicing office nurse one year removed from active hospital nursing, I agree wholeheartedly with Miss Christie in her article "Girl Friday, R.N." (Nov. 1968). However, I also believe that the R.N. in the office can be much more than an extremely competent medical secretary.

In my office, which specializes in obstetrics and gynecology, I am being used far more effectively as a nurse because I spend all the time allotted for office visits with the patients. During this time I am able to teach general health rules to individual patients and to their families, fulfil my duties related to physical and lab procedures and explanations of special treatments, and gather information about the patient's history so that the doctor can use his time with the patient more efficiently.

In this manner the doctor and I work as a team to help patients understand and solve their problems, thereby giving good medical care, both mental and physical, to the patient. – Mary Ann Cutler, Reg.N., Hamilton, Ont.

Smug disrespect toward doctors

An article and two letters published recently in THE CANADIAN NURSE have brought into sharp and uncomplimentary focus questionable nursing attitudes I have observed during the past seven years. The article was "A doctor looks at nursing education" (July, 1968) by S.C. Robinson, M.D. The two letters were both in the October issue – Albert Wedgery's letter headed "Tug-of-war attitude" and Marie Martin's "Incompetent interviewers."

I believe that there is a great lack of communication not only between doctors and nurses, but also between nurses and nurses, and between nurses and patients. I contend that this lack of communication stems at least in part from disparaging and often ignorant attitudes adopted by many nurses toward non-nurses.

Doctors have been too tolerant of sloppy nursing habits, although not unaware of them. They have been too ready to accept responsibility for nurses' shortcomings as well as their own and in so doing have allowed nurses to assume airs of inflated self-importance for pseudocapabilities.

Mr. Wedgery echoes Dr Robinson's views when he writes "... we need immediate and lasting dialogue so that nursing does not continue to get further away from medicine. I suspect that this breach has resulted because doctors as a group have not been concerned about the developments in nursing education and the changes in nursing practice."

Dr. Robinson writes "This, (the breach in dialogue) I believe, is the fault of the medical profession."

Not entirely. I believe that Dr. Robinson has been far too generous in absolving nurses from a healthy share of the blame.

In my experience, most doctors regard nurses with a great deal of respect as individuals and as members of the health team. Almost all doctors are not merely willing but eager to instruct and inform in any area of patient care *when the nurse displays an interest.*

Mr. Wedgery asks "... how often and in what manner have doctors communicated with nurses as members of the team? " I ask, how often and in what manner have nurses sought communication with doctors as members of the team *and been rejected?*

Conversely, I have encountered in nurses at all levels an incredible degree of smug disrespect toward doctors, albeit hypocritically concealed from the physician behind a pretentious mask of servitude.

This is clearly evidenced not only in remarks by staff nurses in dressing rooms, such as "Old flint-face doesn't need half the instruments he asks for" but more appallingly, in direct comments by nurse interviewers. For example: "We really aren't interested in what the doctors have to say; what we want is a record from the nursing office or a report from a director of nursing."

Does the nurse interviewer assume that the director of nursing from her office can better assess the nurse's capabilities than the surgeon to whom she passes the instruments? Yet, as Marie Martin points out in her letter "These same persons admit they have no idea ... what type of procedure is carried out for any condition."

Today, "reassurance" to the patient too often consists of "Don't worry, Mr. Jones; you just relax and everything will be alright."

The nurse is not insincere in her attempts to give reassurance; she is simply thoughtless. She finds it difficult, or doesn't attempt, to picture the patient out of the context of the hospital environment and his illness. She doesn't imagine him as a well social being making contributions as necessary to society as her own.

For example, his time is just as valuable as her own. But nurses – and doctors – seem to lose sight of this, as can be observed day and night in the outpatient and emergency departments of most large hospitals, where patients with comparatively minor ailments are forced to await treatment for anywhere from two to six hours. Though I don't believe that the main fault here lies with the nurses, I do think they could display a little awareness and sympathy for the inconvenience imposed upon the person.

After waiting two hours, a friend of mine politely asked how much longer the wait might be, thinking she might pass part of the interval having coffee. "If you don't want to wait you

letters

can come back tomorrow," retorted the nurse.

It is important to be aware of the psychological changes occurring in a person who is sick; but it is also important to realize that the person is not always sick and that even when he is sick the changes are not total and his personal integrity remains.

If nurses sincerely wish to attain Mr. Wedgery's goal of "a truly professional nursing service to the public," then they might well become acquainted with the fact that the public is people, not merely patients. – Carole Stafford, Reg. N., Toronto.

Stand up and be counted

Re the vis-a-vis about a paid provincial president (August 1968): I wholeheartedly say "yes."

It is most refreshing to hear Monica Angus' point of view, in which she urges the bedside nurse to take a more active part in decisions affecting the welfare of patients, and the working conditions and salaries of nurses.

I am told that there is a fresh wind blowing in nursing, which is long overdue. We must participate at the local level and stand up to be counted. - Berta Schmidt, R.N., Cert. P.H.N., Victoria, B.C.

Why can't the CNA?

At the request of the editorial staff of THE CANADIAN NURSE I attended the Registered Nurses' Association of Ontario regional conference on the use of audiovisual aids in nursing held in Toronto from November 11 to November 14. I had not seen the latest issues of the magazine, nor received any special briefing.

Toward the end of the first day, a few questions occurred to me; I understand that some of them were also asked in an editorial in the October issue (page 33). Throughout the conference, delegates kept asking me what the Canadian Nurses' Association was doing in certain areas. On my return to Ottawa, I found out that as often as not, nothing was being done.

The first speaker was David Clee, professor of education in charge of the Educational Media Center at the College of Education, University of Toronto. He told how teaching has turned away from the didactic, rote-learning approach to that of teaching through dialogue and the enquiry method, using techniques in which the student is the center of the curriculum and emphasis is on the learning process.

The lectures and discussion periods that followed pinpointed several problems:

1. Older teachers, used to the authoritarian approach, feel useless and frustrated when they are faced with a classroom made up of discussing, questioning groups, rather than a block of listening students. There is a need for special training of these teachers.

2. Many teachers do not know how to use equipment and are afraid to experiment with it. As Lou Wise, assistant director, Visual Aids Department, Toronto Board of Education – the second speaker – pointed out, the use of media no longer means ordering the odd 16mm. film and showing a few slides. In Toronto, workshops have been held for the past eight years showing teachers how to make 8mm. movies for use in highschools, and students are participating. The Toronto School Board's Teaching Aid Service supplies technicians for servicing equipment and helping and advising teachers; they hope to have such a technician in all public and separate schools in the city..

Mr. Wise forecast the establishment of a 16mm. film-production center for all the nursing schools in Ontario.

3. For the last two or three years, nursing teachers have been producing their own 8 mm. films. They have begun to realize that there is much duplication of effort and that there is a need for centralization for purposes of exchanges. As a matter of fact, the RNAO set up this series of conferences on audiovisual aids because a voluntary group of nursing school teachers wanted to pool their resources to set up a central agency for auxiliary teaching aids. When this group approached the RNAO last fall, RNAO decided that the need was shared by the province, and organized the conferences on audiovisual aids. Through the RNAO, this group of nursing teachers presented a brief in April 1968 to the Ontario Council of Health, asking for funds to pay the salary of a person who would assess the audiovisual needs in the province. This brief has already been studied by subcommittees, and is expected to go before the council itself any day now.

This need cannot be just province-wide. What is beeing done in other provinces? Should not the CNA act as a coordinating body? (I asked one of the members of the RNAO planning committee whether she thought that the, CNA should be handling a project of this nature and the comment was, "They don't seem to have the money and if fees were raised again, there would be a howl. The need is urgent; we have to do something now; we can't wait for CNA.") The RNAO is supposedly short of money also; if they can find a means of raising funds, why can't the CNA?

There was unanimous condemnation of Trainex film strips, as well as of some other commercially provided visual aids such as slides, because of the gross errors of technique depicted. This points out the need for the establishment of a committee, or at least the appointment of one person to provide consultative services to commercial companies. This person or committee could also advise the textbook companies almost all of which are now putting out slide series to accompany their nursing textbooks. The speakers and the delegates unanimously felt that many of the commercial slides, though accurate and well produced, were unsuitable for their teaching needs.

4. Library services: As I mentioned, textbook companies are now providing slides to accompany books. Is there any reason that these slides should not be available in the same place as the textbooks? Many high school libraries (and not only in the main cities – one of the delegates from a small northern town said the system was in use there in grade seven!) offer study carrels in which students can view slides, 8mm. films, and other material; the equipment is supplied by the library. I met one nursing school librarian who is setting up a five-year plan for the incorporation of audiovisuals; she is thinking of putting teaching aids such as transparencies in the same section as textbooks on the subject.

5. Barbara Smith, Coordinator of Libraries of the Board of Education for the town of Mississauga talked about "Preparing for Information Service in your Future." She pointed out that already the services offered by many libraries include:

– Computerized information retrieval and bibliographical control (computers indicate whether book is in library and, if not, when it is to be returned; all records of the library are made available. Dial access to films, tapes, records, etc. (You sit in the carrel, dial for the necessary film and see and hear it in the carrel).

Facsimile transmission of hard copy through the telephone (printed text is actually reproduced before you).

On-line computer terminals (these look like typewriters; they are linked to a main library where a computer prints information on the typewriter-like machine in front of you).

Miss Smith said that centralization and cooperation are necessary if we are to harness the large amount of information that we are deluged with constantly. Committees are necessary to evaluate materials so that what is produced can be either shared or reproduced. Decisions dealing with information storage and retrieval should be made with automation in mind. This could save millions of dollars. Miss Smith mentioned a computerized central medical library in Washington; is it not likely that a central computerized library will be necessary in Canada in the not-so-distant future, and should not the CNA start to plan for it?

6. Other questions regarding CNA that were put to me at the conference include: "Is there a quick reference guide to evening classes and other classes given in nursing schools across Canada? " and "Do you have any French books in your library? I don't remember having seen any."

This brings up another major issue. When plans are being made to introduce audiovisual aids and other forms of automation, should not provision be made at the very beginning to have bilingual services? For example, if you are planning to have transparencies, overlays should be provided in both languages; soundtracks also should be in both languages. When slides or other materials are ordered from a commercial source, attemps should be made to obtain the text in French: you will notice that more and more commercial audiovisual aids are made available in both languages.

The CNA is a national association; it is incredible that of its professional staff, only the editors of *L'infirmière canadienne* speak fluent French. When the association plans to introduce changes made necessary by automation, should it not without hesitation hire additional professional staff that is bilingual? – Ramona Macdonald, former assistant editor, *L'infirmière canadienne.* □



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news

Canadian Elected Chairman Of PAHO Nursing Committee

Washington, D.C. – A Canadian nurse has been elected chairman of a newly-formed committee that advises the Pan American Health Organization on ways and means of developing its nursing program in Latin America.

She is Dr. Helen K. Mussallem, executive director of the Canadian Nurses' Association, Ottawa. She was elected chairman of the first meeting of the PAHO Technical Advisory Committee on Nursing. The seven-member, international group is made up of experts from Brazil, Canada, Chile, Colombia, Mexico, Panama, and the United States.

The ratio of nursing personnel for Canada an the United States, according to PAHO figures, is 2.2 nurses and 2.6 nursing auxiliaries for every physician. It is 0.7 and 1.6 respectively for the countries of Middle America, and 0.4 and 1.1 respectively for those of South America. Thus, a major item for discussion was the type of program Latin American countries might develop to alleviate the nursing shortage, rated the area's most serious health-personnel problem. How a country can best put its nurses to work in the care of patients was another item on the agenda, as was the education of university trained nurses, and of nursing auxiliaries.

CCUSN Elects Executive

Ottawa, Ont. – The executive officers of the Canadian Conference of University Schools of Nursing were named at a meeting of CCUSN Council held in Ottawa, November 5 to 7, 1968. Margaret MacPhedran, director of the School of Nursing, University of New Brunswick, was named President.

Sister Jean Eudes, Mount St. Vincent University, is first vice-president, Jean Godard, McGill University, is secretary, and Carolyn Pepler, University of New Brunswick, is treasurer. Margaret Hart, University of Manitoba, is past-president.

Regional advisors are: Margaret Bradley, Dalhousie University, for the Atlantic region; Sister Marie Bonin, University of Montreal, for the Quebec region; Marion Woodside, University of Toronto, for the Ontario region; and Alice Baumgart, University of British Columbia, for the Western region.

The CCUSN Council, which consists of the deans and directors of the 21 university schools of nursing plus two representatives from each of the four regions, was meeting concurrently with the Association of Universities and Colleges of Canada (AUCC).

CCUSN is an organization of university schools of nursing in Canada and has existed since 1942. This summer at its annual meeting

Well-Known Speakers To Address ICN

Ottawa. – Many well-known persons from every corner of the globe will address the plenary sessions at the 14th Quadrennial Congress of the International Council of Nurses in Montreal, June 22-28, 1969. The Canadian Nurses' Association's coordinator with the ICN Congress Committee, Harriet J.T. Sloan, told CNA staff in December that most Congress speakers have now been obtained.

Lester B. Pearson, former prime minister of Canada, will speak at the first plenary session on Wednesday, June 25. The topic of this morning session is *Forecasting The Future*, and Mr. Pearson will discuss the cultural, social, and economic factors that will affect nursing. Chairman of the morning's session will be Mlle Alice Clamageran, of France, first vice-president, ICN.

Other speakers at the first plenary session include: Dr. J.D. Wallace, executive director, Toronto General Hospital, and Miss N.K. Lamond, South Africa. Their sub-topic is "Technological Change in Nursing." Miss Lucy Germain, assistant director, Pennsylvania Hospital, Philadelphia, USA, will then discuss "Technological Change in Administration."

Implications of Change is the topic of the afternoon plenary session on Wednesday, June 25. Chairman Mrs. K. Pratt, Nigeria, third vice-president, ICN, will introduce the speakers, who are: M. Claude Tellier, a Montreal barrister, and Miss J. Sotejo, dean of nursing, University of the Philippines. Their sub-topic is "Technological Change and the Law." Dr. Leo A. Dorais, director of permanent education, University of Montreal, and Miss Nelly Garzon, faculty, National University of Columbia, Bogota, Columbia, South America, will speak on "Technological Change and Human Relations."

Thursday morning's plenary session, *Education for Today and Tomorrow: Basic Programs*, will be chaired by CNA President Sister Mary Felicitas. Speakers and their topics are: Dr. Philippe Garigue, dean, faculty of social sciences, University of Montreal: "Patient and Family-Centered Care"; Miss Ingrid Hamelin, Finland: "Program Patterns in Basic Nursing Education"; Miss Florence MacKenzie, director of nursing education, The Montreal General Hospital: "The Hospital School in Canada"; and Dr. Mildred Montag, professor of nursing education, Teachers College, Columbia University, N.Y.: "The Junior College Program in the U.S.A."

Later on Thursday morning, a panel will discuss "The Basic Program at the University Level." Panelists include: Dr. Rozella Schlotfeldt, U.S.A.; Miss Sheila Collins, U.K.; Miss T. Agah, Iran; Miss M. Kaneko, Japan; and Mr. M.A. Ahad, India.

The plenary session on Thursday afternoon will be chaired by Miss E. Louise Miner, CNA president-elect. The topic is *Education for Today and Tomorrow: Post-Basic and Post-graduate Programs.* Mlle Jane Martin, France, will speak about "Aims for Tomorrow." A panel discussion about "Teaching Tomorrow's Nurses" will be chaired by Dr. Gerald Nason, president of the Canadian Teachers' Federation. Panelists include: Miss B. Salmon, New Zealand; Miss W. Hector, U.K.; Mlle J. Demaurex, Switzerland.

Speakers at Friday morning's plenary session include: Gilles Paquet, Carleton University, Ottawa, who will discuss "Health Care Economics"; Bernard Blishen, dean, graduate studies, Trent University, whose topic is "Socialized Medicine or Not?"; Miss E. Cantwell, U.S.A., who will discuss "The Nurse – Personal Security"; and Mrs. G. Zetterstrom Lagervall, Sweden, who will talk about "The Professional Association and Economic Security for the Nurse."

Dr. Robert Merton, the well-known U.S. sociologist, is the first speaker at the Friday afternoon session, which will be chaired by Miss Ruth Elster, Germany, second vice-president, ICN. Under the topic *Leadership in Action*, Dr. Merton will discuss "The Nature of Leadership." He will be followed by Miss J.C. Rodmell, Australia, and Miss Antje Grauham, Germany, who will discuss "Leadership and the Administrative Process" and "Education for Leadership" respectively.

The two final speakers on Friday are: Mrs. Jytte Kiaer, Denmark, who will speak about "Leadership for Technological Advance in Nursing"; and Professor Charlotte Searle, South Africa, who will discuss "Leadership in the Nursing Context of Tomorrow."

The ICN governing body, the Council of National Representatives, meets Monday and Tuesday, June 23 and 24. All Congress participants are invited to attend these sessions as observers.

Special offer to CNA members

"The Leaf and The Lamp"

CNA's Diamond Anniversary Publication

The Canadian Nurses' Association proudly announces that its 60th anniversary publication, *The Leaf and The Lamp*, will be available in mid-May.

An overview of the first 60 years of the CNA, *The Leaf and The Lamp* brings quickly into focus Canadian nursing as it is today, and will be tomorrow; then dips back into history for a review of the origins, beginnings and highlights of the profession in Canada.

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it radically changed the structure of the Conference in an effort to take a stronger and more active role in higher education for nurses.

OHSC Raises Bonus Rates For Service Personnel; Teachers' Bonuses Remain Same

Toronto. – The Ontario Hospital Services Commission has agreed to *raise* the bonuses to university-trained nursing service personnel and not to *lower* the bonus paid to university-trained teachers of nursing. The OHSC had previously suggested that salary bonuses paid for university educational preparation should be equal for nursing service personnel and nursing education personnel, but wanted to equalize the two by lowering the teachers' rates.

The new rates for both service and education personnel are $40.00 a month for one-year university preparation, $80.00 a month for bachelor's preparation, and $120.00 a month for master's preparation. This is the same rate that has been given to teachers for the past three years.

The service personnel rates were raised from a $25.00/$55.00/$100.00 scale.

The new rates were put forward at a meeting of representatives from the Ontario Hospital Association, the Ontario Hospital Services Commission, and the Registered Nurses' Association of Ontario.

The rates are lower than those recommended by the Registered Nurses' Association of Ontario. However an RNAO spokeman said that the organization was satisfied with the new rate.

CEGEP System Explained At ANPQ General Meeting

Montreal. – The operation of the Collèges d'enseignement général et professionel was the topic of a speech given by Thérèse D'Aoust to the general meeting of the Association of Nurses of the Province of Quebec. The meeting was held in Montreal October 31 to November 1.

CEGEP colleges offering nursing have increased from 12 in 1967 to 20 in 1968. Dawson College in Montreal is expected to open the first English-language school in September, 1969.

Miss D'Aoust explained that there is only one category of instructor within the system, responsible for theory, clinical teaching, clinical programs, supervision of clinical orientation, clinical evaluation, laboratory sessions in nursing care, and evaluation of nursing care demonstrations.

Rita Lussier, of the Quebec Hospital Association, questioned Miss D'Aoust about the one category of instructor, saying that a nurse seldom has experience in all fields. Miss D'Aoust pointed out that the instructor would be responsible for only one field of nursing care.

Qualifications of instructors in the CEGEP system are: a master's degree for directors, and a baccalaureate degree for instructors. Preference is given to those who held positions in hospital schools of nursing. An experienced nurse without the required qualifications, but with an outstanding ability to communicate would be considered. Opportunities are provided for instructors to improve their qualifications within the system.

Gift To CNA Archives



Two members of The Montreal General Hospital Alumnae Association examine a collection of nurses' uniforms, caps, and other mementos representing the years between 1915 and 1960. The Ottawa branch of the alumnae association donated the display to the Archives of the Canadian Nurses' Association, Ottawa. On the left is Miss Grace Tanner, sister of the founder of the alumnae association; on the right is Miss Jean Kerr, who at 97 is the oldest living graduate of The Montreal General Hospital. Photo was taken in the CNA library.

RNAO Holds Regional Conferences On Audiovisual Aids

Toronto. – "Today's child is in an image-structured, not a print-structured world, business is 25 years ahead of education in the use of the media and the Church is 25 years behind education." This is how David Clee, professor of education in charge of the Educational Media Center at the College of Education, University of Toronto, explained the "why" of audiovisual aids in education to the 125 delegates attending the Regional Conference on Audiovisual Aids, sponsored by the Registered Nurses' Association of Ontario, held in Toronto, November 11 to 14. Mr. Clee stressed the importance of personal qualities of the teacher and of non-verbal means of communication within the context of the new dialogue approach in teaching: "What I'm told I forget; what I see, I remember; what I do, I understand."

Lou Wise, assistant director of the Visual Aids Department, Toronto Board of Education, highlighted advances in the use of visual aids in the high schools in Toronto and illustrated how some of these aids could be used.

Patricia Prentice, nursing instructor, school of nursing, Ryerson Polytechnical Institute, showed how slides could be prepared and used in nursing education. Betty Bennett, of the Quo Vadis School of Nursing, pointed out some of the ways in which tapes could help nursing teachers. The advantages and disadvantages of overhead projectors using opaque materials and transparencies were explained by Sylvia Mountney of the Nightingale School of Nursing.

Heidi Yamashita, assistant director, Nightingale School of Nursing, gave a breakdown of the costs, equipment, and planning required for the production of home movies.

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The closing speaker was Barbara Smith, coordinator of libraries, Board of Education for the town of Missassauga. Miss Smith stressed the role of libraries as service centers and summarized the types of services presently available and outlined the library services of the future. She also called for greater cooperation between experts in the fields of nursing education and information science.

The lectures were supplemented by question and discussion periods as well as demonstrations.

ICN Congress Registration Continues To Lag

Ottawa. – To date, only 219 Canadian registered nurses and 11 Canadian nursing students have registered for the 14th Quadrennial Congress of the International Council of Nurses to be held in Montreal June 22-28, 1969. "We are somewhat concerned about this slow registration," Harriet J.T. Sloan, the Canadian Nurses' Association's coordinator for the ICN Congress Committee, told CNA staff at a December meeting, "as it is most essential that there are sufficient Canadian nurses to act as hostesses for our international guests." Miss Sloan pointed out that 2,822 of the 6,213 registrants (45.4 percent) at the ICN Congress in Montreal in 1929 were Canadian.

The Congress, which begins on Sunday, June 22, with an Interfaith Meeting at Notre-Dame Cathedral, is expected to attract over 12,000 nurses from all over the world. As of December 6, registration of foreign nurses was 400.

The ICN Congress registration fee is $40 if received by CNA before January 22. Late registrations will be accepted, but the fee will be $60 after that date.

Student registrants are welcome to attend all sessions of the Congress, including the colorful opening ceremonies on Sunday, June 22. Two hundred students from Canada are allowed to register. Applications will be processed on a first-come, first-served basis.

Schools Evaluate Tests As Educational Aids

London, Ont. – "Testing: Frustration or Facilitation" was the theme of the workshop held on November 8 and 9, 1968 in Holdsworth Auditorium, Victoria Hospital, London, School of Nursing. The program, which was planned as an inservice project for the combined faculties of St. Joseph's Regional School of Nursing and the Victoria Hospital School of Nursing was attended by 70 teachers.

Dr. Josephine Flaherty, a specialist in the field of evaluation and testing, shared ideas from her experience and research. Group discussions provided an opportunity for the exchange of ideas and concerns encountered in evaluating nursing students.

Nurses Hold Memorial Service



Ottawa. – The Nurses' Alumnae Association of the Ottawa General Hospital and of the University of Ottawa School of Nursing, held its first Memorial Tribute Service to Canadian Nurses before the Nurses' Memorial, Hall of Honor, Parliament Hill, on November 10.

Margaret Olsiak (right), president of the Alumnae Association, presented a wreath on behalf of her Association. Margaret D. McLean, second vice-president of the Canadian Nurses' Association, represented CNA at the Service. She addressed the assembly and placed a floral tribute before the Memorial.

Shown with Miss MacLean and Miss Olsiak are Rosario Gendron (left), parliamentary secretary to Health Minister John Munro, and Father Paul-Emile Sanschagrin, University Chaplain.

United Nurses Of Montreal Hold Second Annual Meeting

Montreal.– The second annual meeting of the United Nurses of Montreal took place Friday evening, November 29, in the auditorium of the Royal Bank Building, Place Ville Marie.

The United Nurses of Montreal is a union of Professional nurses formed in 1966 by the English Chapter, District XI of the Association of Nurses of the Province of Quebec.

It represents 3,000 nurses in 21 English-speaking hospitals on the island of Montreal, as well as nursing personnel in the Northern Electric Company, the Protestant School Board of Greater Montreal, the City of Westmount, the Victorian Order of Nurses (Greater Montreal, Lachine-Dorval and Ste Anne de Bellevue branches), the Children's Service Center and Child Health Association.

Presented by Wendy D. Rogers, president, on behalf of the executive and board of directors, the report covered the union's activities from November 1, 1967 to October 31, 1968 for both the general membership and the associate group.

Among the subjects Mrs. Rogers summarized were the number of contracts signed, progress of negotiations, finances, education and future plans.

Particular emphasis in the report was given to the union's efforts to teach member nurses the significance of the clauses in the contracts and their importance to them as individuals and to the profession. This was done through organized workshops and UNM councillors.

She also dealt with the progress of the publicity, health insurance, pension plan, and financial committees. One of the union's greatest achievements, stressed Mrs. Rogers, was the formation of the Joint Committee on Nursing. This committee is made up of five members of the UNM, representing various levels in the nursing profession, and of five administrators, representing the administration of English-speaking hospitals in Montreal. It has been working on a definition of the role of the nurse and will continue working out definitions of the different categories of nurses and of nursing itself.

Tribute was paid to executive secretary Margaret K. Stead. Mrs. Rogers said that Miss Stead's knowledge of labor relations and her expert guidance through negotiations had been invaluable assets to UNM. Mrs. Rogers was also gratified to note that the UNM had become involved in government and professional activities. For example, last March it was invited to send a representative to the meetings on the Superior Council of Nursing, a government

committee under the Minister of Health, which studies, among other subjects, the workload of nurses.

The UNM is also a member of the advisory committee set up by the Department of Education for the CEGEPs, under which system nurses in the diploma course will be trained in Quebec in the future.

Mrs. Rogers mentioned the union's fruitful association with SPIQ, (Syndicat Professionnel des Infirmières du Québec), a union of 3,000 nurses located chiefly in hospitals in Quebec City and centers throughout the province.

Together, SPIQ and UNM represent more than 6,000 nurses, the largest group of unionized nurses in the province.

The two unions present their contracts together to the Association of Hospitals of Quebec and the Department of Health.

Negotiations commenced last April and meetings take place regularly, reported Mrs. Rogers. To date, a number of nonmonetary clauses has been settled satisfactorily. Plans for the future include restructuring the constitution of the UNM to provide for an enlarged membership.

Copies Of Speeches Requested So Requested Speeches Copied

Ottawa. – So many requests have been received for copies of the papers presented at the clinical sessions held during the Biennial Convention of the Canadian Nurses' Association in July that the Association has decided to publish them.

Valerie Fournier, CNA Public Relations Officer, has announced that the papers will be presented in mimeographed form in a single volume. The cost will be $2.50.

Not all the papers are presented, as some speakers did not supply copies of their speeches. However, the volume contains those papers from the sessions on nurses and the practice of nursing, continuity of patient care, Canadian testing service, clinical fields in nursing education, and clinical research in nursing.

NBARN Organizes For Collective Bargaining

Fredericton. – The Provincial Collective Bargaining Committee of the New Brunswick Association of Registered Nurses met for the first time on November 28th and 29th, 1968. This historic meeting, which was held in Fredericton, was a further step in preparation for collective bargaining under anticipated labor legislation. Committee members were assisted by Glenna Rowsell, Consultant in Social and Economic Welfare of the Canadian Nurses' Association, Ottawa.

The Provincial Committee will form part of the provincial collective bargaining structure. This structure was designed to function on a province-wide basis under the anticipated legislation. The 12-member committee represents all nurses' staff associations in the province.

The majority of nurses in New Brunswick are included under the new Public Service Labour Relations Bill, which has gone through second reading in the Legislature. This will provide the collective bargaining framework for nurses and other public servants once it is declared law. The Bill would provide a choice of arbitration *or* strike vote for public service employees.

At present, New Brunswick nurses do not have collective bargaining rights.

Possible Change In RNAO Bylaws

Toronto. – Members of the Registered Nurses' Association of Ontario will be asked to vote on changes in the categories of membership at the Annual Meeting May 1-3, 1969. If accepted, the changes, which were recommended by the RNAO board of directors at its meeting November 22-23, would take effect in 1970.

Prior to 1966, there were four types of membership in RNAO: honorary, active, associate, and inactive. In 1966, the bylaw was changed, reducing the number of categories to two: honorary and regular. The present membership fee for regular members is $35 per year.

The RNAO board of directors recommends that the bylaws be changed to permit:

- An affiliate membership with a fee of $18. for the non-working nurse. If the nurse returns to work, she would pay a differential fee of $17.
- An out-of-the-province affiliate membership at $12.
- An affiliate membership with a fee of $18 for registered nurses who are enrolled for full-time study at university.
- An associate membership with a fee of $18 for graduate, non-registered nurses who are members of local collective bargaining units recognized by RNAO under the requirements of the Labour Relations Act in Ontario. This change would be reviewed in three years.
- Present membership in RNAO, which is voluntary, is approximately 13,000.

Aspirin May Cause Ulcers.

Chicago. – Aspirin may contribute to the formation of gastric ulcers, according to a report presented to the 54th Annual Clinical Congress of the American College of Surgeons in Atlantic City.

Drs. René Menguy and Martin H. Max, of the Pritzker School of Medicine, University of Chicago, said investigation showed that aspirin taken orally significantly impairs the ability of cells to produce a protective mucous coating. Recent research with dogs has shown that aspirin administered so that it does not come into contact with the stomach lining causes an increased loss of cells from the lining, due to the action of circulating aspirin rather than direct contact.

Over 20 million pounds of aspirin is consumed annually in the United States.

Haute Couture On The Wards



Montreal. – It isn't a famous Dior or Balanciaga model – but it looks just as good. The new uniform for nursing students at the Collèges d'enseignement général et professionnel (CEGEP – Colleges of general and professional education) was designed to be both practical and beautiful.

The white, one-piece, loose-fitting, short-sleeve dress buttons down the left front in a modified "Ben Casey" style. A uniform for male students has a similarly shaped jacket worn with white trousers.

The uniforms will be worn in all CEGEPs throughout the province. They have been on trial in three schools already and have proved satisfactory.

ANPQ Committees Discuss Uniform Nursing Techniques

Montreal. – Two meetings of the nursing and education committees of District XI, of the Association of Nurses of the Province of Quebec, were held in October and September to establish uniform nursing techniques that might be applied in hospitals throughout the province. The meetings were intended to provide opportunities to analyze and develop the nursing techniques.

Sister Bernadette Poirier, director of nursing at Notre-Dame Hospital in Montreal, spoke of the basic criteria of the nursing profession, the purpose of nursing studies, and outlined relationships between nursing and the government. P. Desautels, Claudette Domingue, and Evelyn Adam took part in a round-table discussion following the talk.

The two meetings were held at Jean Talon Hospital and Notre-Dame Hospital in Montreal. Some 225 nurses attended.

news

RNABC Donates $ 5,000 To CNA For ICN Costs

Vancouver. – The Registered Nurses' Association of British Columbia donated $5,000 to the Canadian Nurses' Association in December to help defray expenses for the 14th Quadrennial Congress of the International Council of Nurses to be held in Montreal June 22-28, 1969. RNABC is the second province to make a donation. Last month the Registered Nurses' Association of New Brunswick donated $5,205.

Commenting on RNABC's generous contribution, Dr. Helen K. Mussallem, CNA executive director, said that the gift is a most welcome one in view of the heavy expenses that are involved in being the hostess country.

At least four provinces, including British Columbia, Ontario, Manitoba, and New Brunswick are sending their public relations officers to help the CNA press team at the ICN Congress. More than 100 representatives from nursing journals, newspapers, TV, and radio are expected to cover the Congress.

Pembroke Hospital Sponsors Team Nursing Workshop

Pembroke, Ont. – "There's a better way – find it." That is the motto Thora Kohn, an U.S. expert on team nursing, told 83 nurses attending a three-day Workshop on Team Nursing held at the Pembroke General Hospital, October 22 to 24. Mrs. Kohn is author of two books on team nursing, *Team Nursing Leadership* and *Communication in Nursing.*

The Workshop, part of the hospital's in-service education program, was attended by nurses from six eastern Ontario centers. It included topics on communication, formulation and use of nursing care plans, team conferences, easy steps in team nursing, and leadership in team nursing.

Dorothy Desjardin, inservice education coordinator at Pembroke General Hospital and chairman of the workshop committee, commented on the interest and eagerness of nurses to reorganize their methods of team nursing. "We would like to emphasize for the benefit of other nurses the advantages of team nursing and the fact that it can be implemented in most nursing unit assignments," she said.

Lung Cancer On Rise In Canada

Ottawa.–The death rate from the lung cancer epidemic plaguing Canada increased 10 percent between 1966 and 1967, reports the Minister of National Health and Welfare John Munro. The disease caused 4,318 deaths in 1967, up from 3,844 in 1966. Of these deaths, 3,700 occurred among men, 618 among women. The rate per 100,000 population, statistically standardized to the 1961 census population to allow comparison, was up for men from 32.9 in 1966 to 36.3 in 1967. For women the increase was from 5.3 to 5.8.

Lung cancer is now the leading cause of death from cancer in Canada for men and for men and women combined. Twenty-four percent of male cancer deaths and five percent of female cancer deaths were due to this disease in 1967.

"The tragedy is that so many lung cancer deaths are preventable," Mr. Munro said. "Most are attributable to cigaret smoking. Obviously the best prevention is for a person to never start the habit. However, it usually takes many years of exposure to cigaret smoke before lung cancer develops. As long as the disease is not already present, on discontinuance of smoking the risk of its development gradually decreases until it approaches that of a non-smoker. The risk of other cigaret-smoking diseases – chronic bronchitis, emphysema, and coronary heart disease – also decreases when the habit is dropped.

"There is, unfortunately, a time lag between changes in smoking practices and mortality from related diseases." Mr. Munro added. "Favorable changes in the former are not immediately reflected in the statistics. However, the benefits of discontinuing smoking are already indicated by the experience of British doctors, a large number of whom have stopped. Between the periods 1954-57 and 1962-64, the doctors' lung cancer death rate *decreased* 30 percent while that of British male population *increased* 25 percent.

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MARN Co-sponsors Program For Inactive Nurses

Winnipeg. – If Manitoba is to attain the recommended minimum of 450 nurses per 100,000 population by 1970, an annual increase of five percent must be maintained. To this end the Manitoba Association of Registered Nurses and the Manitoba Hospital Commission are co-sponsoring a refresher course for inactive nurses who have been previously registered.

The shortage of nurses in Manitoba eased slightly during the fall after an acute shortage during the summer. There are still shortages in parts of the province, however.

Although no new hospital beds were opened in Metropolitan Winnipeg during 1968, additional facilities are presently being planned or are in construction, and they will require additional nurses. MARN maintains the shortage is due to too many nurses being held in administrative or clerical duties, while non-skilled personnel are caring for patients. The high mobility rate of Manitoba nurses increases the problem.

BC Nurses Begin Two Workshops

Vancouver. – Twenty-three nurses began the first in a series of Intravenous Therapy Courses at St. Paul's Hospital, Vancouver, on Sept. 9. The courses are sponsored by the hospital, the Registered Nurses' Association of British Columbia, and the B.C. Hospital Association. The second in the series is to begin February 14. The entire group takes a week of theory and then groups of four nurses return for the clinical part of the course. Because of this, the second course will extend until June 27.

The first in a series of eight-week Intensive Care Nursing courses begins at Vancouver General Hospital on January 6. This is sponsored by The Vancouver General Hospital, RNABC, and BCHA. The B.C. Hospital Insurance Service is underwriting the cost of the full-time instructor, Shirley Stokes, who has worked for several years in the clinical area of intensive care and emergency at The Vancouver General Hospital.

Housing Affects Health

Ottawa. – Health workers can influence planning for housing and help to ensure that it is based on social, cultural, and personal needs, according to a consultant with the Department of National Health and Welfare.

Dr. H.N. Colburn presented a paper entitled "Health and Housing" to the Canadian Conference on Housing, meeting in Toronto October 20-23. Health workers have a special contribution to make, according to Dr. Colburn, because of their knowledge of people as individuals rather than masses. For the most part they are not making this contribution, he stated.

Dr. Marvin Lipman, a consultant on urban environment with Central Mortgage and Housing Corporation, stresses an increasing need for a greater range of choices in housing environment for all Canadians, including low-income groups. More amenities to make the home not merely a shelter, and more opportunities in housing to allow for varied forms of management and ownership are also necessary.

The Canadian Conference on Housing was sponsored by the Canadian Welfare Council, with the financial support of Central Mortgage and Housing Corporation, the Ontario provincial government, and industry.

"Fasten Seat Belt, Please"



Pontiac, Mich. – The American Seat Belt Council's new safety slogan, "Don't be a Buckle Boob," is penetrating even into hospital halls, as noted here. Barbara M. Gast of Royal Oak, Michigan, buckles up in her wheelchair at St. Joseph Mercy Hospital, Pontiac, Michigan, at the direction of nurse Jane Gallagher. Hospital installed, the belts protect weak or very ill patients who might otherwise tumble from chairs. American Safety Equipment Corporation helped solve the problem with a special adaptation of its airplane seat belts, standard on many airlines. Barbara, who had an accident with her car on her way to classes at Oakland University, now has a double appreciation of the value of seat belts.

Father Should Dominate Says Hamilton Doctor

Vancouver. – The dominant member of the family should be the father, even during pregnancy and labor, according to Dr. Murray Enkin of Hamilton, Ontario.

Dr. Enkin was speaking to a meeting sponsored by the National Childbirth Trust in Vancouver October 3. He said that the dominant role during pregnancy and labor can be maintained by training the husband, who then trains his wife, in the psychoprophylactic method of childbirth. During labor, it is the husband who will give the commands, rather than a doctor.

Dr. Enkin, who teaches the psychoprophylactic method at St. Joseph's Hospital, Hamilton, illustrated his lecture with slides. Some 100 nurses, prenatal teachers, and obstetricians attended the meeting. □

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New Nursing Books

Understand how and why drugs act

The Pharmacologic Basis of Patient Care

by Mary Kaye Asperheim, B.S., M.S., R. Ph., University of Wisconsin Hospitals.

This brand new text and reference uses a refreshing new approach to pharmacology. Instead of giving a list of diseases, drugs, and dosages to be memorized by rote, it explains the basic principles and concepts so that you understand how specific drugs work and why they are used. Miss Asperheim gives excellent brief reviews of the chemistry and physiology involved in drug action, and offers a concise "refresher course" in the mathematics of drugs and solutions. She discusses methods of administration; the absorption, fate, and excretion of drugs; allergic reactions and immunity. Then she takes up each class of drugs in turn, from topical antiinfectives to radioactive drugs. All important information on each drug is presented in one place. Chapters on diagnostic drugs, toxicology, and drug addiction and habituation complete the coverage. Each chapter opens with an outline of the important concepts to be discussed, and ends with questions for discussion and review.

417 pages, illustrated. $7.60. New — Published October, 1968.

Facts that concern every nurse

The Nurse and the Law

by Harvey Sarner, LL.B.

In this fact-filled new book, an experienced attorney gives sound, constructive advice on problems that every practicing nurse must face daily. In a clear, direct style, he explains such complicated subjects as malpractice, negligence, liability, and privileged communications. He discusses contracts, wills, and workmen's compensation; tells how to get the best insurance coverage for your particular needs at the lowest cost; shows you how to make secure provision for your own retirement; and points out ways you can minimize your taxes. A wise counselor, Mr. Sarner advises you not only on how to meet legal problems, but on how to avoid them — advice that no nurse can afford to be without.

219 pages. $7.05. New — Published April, 1968.

Appreciate nursing's heritage

History of Nursing

by Josephine Dolan, R.N., M.S., University of Connecticut.

From the magic of the witch doctor to the miracles of modern surgery, this well-known text traces the influences of religion, medicine, and the biological and social sciences and weaves them into a comprehensive picture of the emergence of nursing as a profession. In the New (12th) Edition, just published, Miss Dolan has completely revised and considerably expanded the text and added thirty new illustrations. You'll find the most recent developments in nursing practice described, including Project HOPE, the Peace Corps, and the important changes in the structure of the National League for Nursing that were effected in 1967.

380 pages with 310 illustrations. $9.20. New — Published August, 1968.

Concise review of current clinical nursing

Saunders Tests for Self-evaluation of Nursing Competence

by Dee Ann Gillies, R.N., M.A., Cook County School of Nursing, and Irene Barrett Alyn, R.N., M.S.N., University of Illinois.

This new self-teaching and self-evaluating review of clinical nursing is ideal for students and graduates who are preparing for examinations as well as for nurses changing to a new specialty or returning to practice after an absence. For each specialty area — Maternity and Gynecologic, Pediatric, Medical-Surgical, Psychiatric — the authors describe typical case histories and presenting situations, then ask a series of perceptive questions about them. As the case develops, more information is introduced and more questions asked. Each unit includes a helpful bibliography and there is a complete index. Perforated IBM-type answer sheets (and correct answers) are provided.

426 pages. $7.30. New — Published April, 1968.

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☐ Sarner: **The Nurse and the Law** ($7.05) ☐ Gillies & Alyn: **Self-evaluation** ($7.30)

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names



Sally Tretiak



Glenna M. Gorrill

Sally Tretiak (B.A., U. Manitoba; R.N., Winnipeg General; M.A. (Admin.N.Ed.), Columbia U., New York) and **Glenna M. Gorrill** (R.N., Galt School of Nursing, Alta.; Dipl. Teach. and Superv., U. Alberta; B.Sc. N., Lethbridge Junior College, U. Alberta; M.N., U. Washington) have joined the teaching staff of Red Deer Junior College in Red Deer, Alberta.

Miss Tretiak served with the World Health Organization as an educator in south-east Asia before becoming associate professor at the school of nursing, University of Alberta. Her earlier career included numerous positions as staff nurse, supervisor and instructor in Manitoba, Ontario, and Nova Scotia.

Miss Gorrill's career has been centered in Lethbridge, Alberta. She was head nurse at Galt Hospital; assistant associate director of nursing service at Lethbridge Municipal Hospital; and associate director of nursing education at Galt School of Nursing.



Mary Peever (R.N., Royal Victoria H., Montreal; Cert.P.H.N., B.N., U. Man.; M.Sc., U. Colorado) was appointed chairman of the department of nursing education at Mount Royal Junior College, Calgary, in August 1968. Prior to this appointment, Miss Peever was instructor in maternal and child nursing at the College (see "Names" April 1968).

Appointed assistant professor in public health nursing at the University of Saskatchewan is **Jean Coppock** (R.N., Alberta H., Ponoka; B.N., McGill; M.Sc., Boston U., Mass.).

After working as a staff nurse and then head nurse at Alberta Hospital in Ponoka, Miss Coppock was appointed nursing supervisor at Larned State Hospital, Kansas. After spending two successive years as staff nurse at Eloise State Hospital in Wayne, Michigan, and at St. Francis Hospital in Honolulu, Hawaii, she returned to Canada where she was appointed head nurse at Alberta Hospital in Edmonton.

From 1964 to 1966, she was employed by the World Health Organization at the University of Ghana, Africa, as instructor in clinical psychiatric nursing.

Three appointments have been announced to the faculty of the school of nursing at Oshawa General Hospital, Ontario.



Marjorie Hicknell (Reg.N., St. Mary's H., Kitchener; Dipl. N. Ed., B.Sc.N., U. Western Ont.) has been named assistant director of nursing education. Miss Hicknell has worked in Sudbury, Edmonton, London, and Sarnia as a staff nurse. She spent eight years as a teacher in the school of nursing, Victoria Hospital in London, Ontario.

Megan Russell (B.N., U. Manitoba) has been appointed as a teacher. Mrs. Russell previously taught at The Children's Hospital of Winnipeg.

Audrey Wilson (Reg.N., Toronto General; B.Sc.N., U. Western Ont.) is named medical-nurgical teacher. Mrs. Wilson worked for 10 years at the Montreal Neurological Institute as general staff nurse, head nurse, and instructor.



Hazel Wilson (Reg.N., Ottawa Civic H.; Cert. Admin. & Superv., P.H.N., B.Sc.N., U. Toronto; Cert. P.H.N., M.Sc.N., McGill) has recently been appointed to the Research and Planning Branch of the Ontario Department of Health.

Miss Wilson worked as a public health nurse in Alberta, Manitoba, and Ontario. From 1951 – 1959 she was supervisor of nursing in the Kenora and district health division. Prior to attending McGill, she was regional consultant with the public health nursing branch of the Ontario Department of Health.

The board of directors of the American Nurses' Association has announced the resignation of **Judith G. Whitaker**, R.N., as executive director. Before assuming her post in 1958, Mrs. Whitaker had served as deputy executive director for six years.

The president of ANA, Dorothy A. Cornelius, paid tribute to Mrs. Whitaker, saying: "During her tenure as executive director, the Association has increased its membership, more than doubled its staff and operating budget, and effected a basic reorganization in order to extend its activities and functions on behalf of nursing in the public interest. Mrs. Whitaker has visited and worked with the constituent associations in all 50 states and has served on a variety of national and international commissions dealing with virtually every aspect of nursing."

Mrs. Whitaker has agreed to continue to serve as executive director until September 1969 to enable the Association to select a successor. The board of directors has expressed regret in accepting the resignation but hopes that Mrs. Whitaker will continue at least for a time to serve the Association in some other capacity.



Margaret E.V. Irwin (Reg.N., Hamilton Civic H.; B.Sc.N., U. Western Ont.; B.L.S., U. Toronto) has returned to the Victoria Hospital School of Nursing as librarian.

Before attending library school, Miss Irwin worked successively as staff nurse, instructor, and librarian at the Victoria Hospital School of Nursing.



Catherine Reban (B.Sc.N., U. Sask.) has been named instructor of nursing fundamentals at Mount Royal Junior College in Calgary. Miss Reban worked for a number of years with the Saskatchewan Department of Public Health in Rosetown and with the Alberta Department of Public Health in Calgary. She also taught maternal and child care for one year at University Hospital in Saskatoon.

Several new staff members have been appointed to the faculty of the University of Toronto School of Nursing. Named assistant professors are: **Norma Dick** (B.A., B.Sc.N., U. British Columbia; M.Sc.(A), McGill), formerly supervisor of inservice education at The Vancouver General Hospital; **Hilda Mertz** (B.S.(N.Ed.), U. Pittsburgh, Pennsylvania; M.S.N., Yale U., Connecticut), formerly director of clinical nursing in McLean Hospital, Massachusetts; and **Beverly Mitchell** (B.Sc.N., U. British Columbia; M. P.H., Michigan U.), who, prior to her appointment, was director of nursing services, Mental Health Services, Vancouver.

ICN President Receives Order of Canada



Alice Girard, president of the International Council of Nurses, was among 27 outstanding Canadians who were invested in November with the Medal of Service of the Order of Canada. The investiture ceremony took place at Rideau Hall, Ottawa and was presided over by Governor-General Roland Michener.
After the ceremony, a private dinner was held at Government House. Dr. Mussallem, executive director of the Canadian Nurses' Association, attended as Miss Girard's guest.

Named lecturers are: **Michelle Brideau** (B.Sc.N., U. Ottawa; M.Sc.N., U. Western Ontario); **Diana Gendron** (B.Sc.N., Florida State U.; M.N.Ed., U. Syracuse, New York); **Margaret Wyness** (B.Sc.N., U. British Columbia); **Vivian Ewart. Jane Harlock, Elizabeth Jack, Eva Kandorovskis, Mary McCulley, Judith MacKay, Ruth Winkler,** all graduates of the University of Toronto School of Nursing.

The newly appointed lecturers will assist in clinical teaching.



Ottilia M. Bieber (R.N., Regina Grey Nuns' H.; Dipl. P.H.N., U. Saskatchewan; B.N., McGill) has been appointed public health nursing education consultant with the public health nursing division of the Saskatchewan health deparment.

Miss Bieber will take part in the expansion and coordination of field experience in public health nursing for students from the university and the diploma schools of nursing in Saskatchewan.

Before joining the provincial health department in 1957, Miss Bieber held positions in doctors' offices, general hospitals, and was an epidemiology worker with the venereal disease control division of the British Columbia health and welfare department.

Since joining the Saskatchewan department, she has provided public health nursing service as a staff nurse and was assistant to the regional nursing supervisor in the Weyburn-Estevan health region. She was promoted to regional nursing supervisor of the Yorkton-Melville health region in 1960 and transferred to a similar position in the Regina rural health region in 1963.



Nicole Du Mouchel (R.N., Ste.-Justine H., Montreal; B.Sc.N. (Admin.), Institut Marguerite d'Youville, Montreal; M.Sc.N., U. Montreal) has been awarded the Warner-Chilcott scholarship, which will enable her to study nursing abroad. Upon her return, she will report in detail on her trip.

This is the second year that the pharmaceutical firm Warner-Chilcott has offered a scholarship to students graduating from the faculty of nursing, University of Montreal. Last year, Mariette Desjardins and Sister Lorraine Beaudin toured the Scandinavian countries on a Warner-Chilcott scholarship. The report of this trip is about to be published.

This year, three students at the master's level qualified for the scholarship: Sister Rachel Rousseau, Lisette Arcand, and Nicole Du Mouchel. As the judges could not come to a decision, lots were drawn. The name of the winner was announced at the annual meeting of the Association of Nurses of the Province of Quebec held in Montreal, October 31 to November 1, 1968.

Next Month in

The Canadian Nurse

- hyperbaric oxygen units
- two-year nursing programs
- nursing service organizations, – a modern approach

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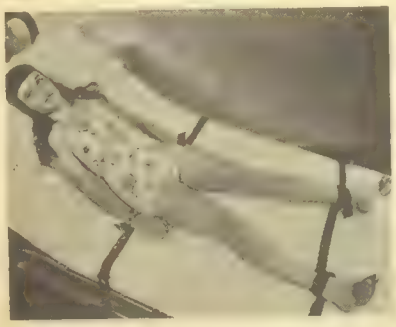
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dates

August 1968 - June 1969
The National League for Nursing is sponsoring a series of 12 two-day workshops in several U.S. cities for persons involved in administration, planning, and evaluation of hospital nursing services. The first workshop was held in San Francisco August 9, 1968, and the last will be held in Miami Beach, June 26-27, 1969.

The workshops are designed for nurses and others interested in nursing audits, new staffing patterns, and hospital staff development programs.

Further information and application forms for registration may be obtained from the Department of Hospital Nursing, National League for Nursing, 10 Columbus Circle, New York, New York 10019.

January 20-23, 1969
February 10-13, 1969
March 20-23 1969
April 14-17, 1969
Regional conferences on the use of audiovisual aids in nursing, sponsored by the Registered Nurses' Association of Ontario. To be held in London in January, Sudbury in February, Ottawa in March, and Fort William in April. Fee: RNAO members, $25; non-members, $35. Write to: RNAO, 33 Price St., Toronto 5.

February 17-19, 1969
Second Canadian Conference on Hospital-Medical Staff Relations, Chateau Frontenac, Quebec City. Theme: Better communications for better patient care. Sponsored by Canadian Hospital Association, Canadian Medical Association, and Canadian Nurses' Association.

February 24-27, 1969
Association of Operating Room Nurses, 16th annual meeting, Cincinnati, Ohio.

March 24-29, 1969
Symposium on recovery room and intensive care nursing, Grace General Hospital, Winnipeg. Registration: $20. For further details: Miss J.W. Robertson, Director - Inservice Education, Grace General Hospital, 300 Booth Dr., Winnipeg 12.

April 13-17, 1969
American Association of Neurosurgical Nurses Meeting, Cleveland, Ohio. Information may be obtained from: Miss S.M. Sawchyn, 99 Fidler Ave., St. James 12, Manitoba.

May 19-23, 1969
National League for Nursing, 1969 convention. To be held in Cobo Hall, Detroit, Michigan. Fee: NLN members, $15; non-members, $25. Write to: NLN, 10 Columbus Circle, New York, N.Y. 10019.

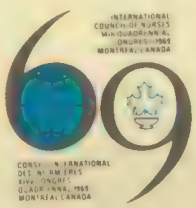
May 21-23, 1969
Registered Nurses' Association of British Columbia, annual meeting, Bayshore Inn, Vancouver. Write: RNABC, 2130 W. 12th Ave., Vancouver 9.

May 21-23, 1969
Canadian Hospital Association, 2nd national convention, Civic Centre, Ottawa.

June 1-13, 1969
Eighth annual residential summer course on alcohol and problems of addiction, Trent University, Peterborough, Ont. Co-sponsored by Trent University and the Addiction Research Foundation, an agency of the province of Ontario.

June 16-18, 1969
Conference on nursing education for visitors to the International Council of Nurses Quadrennial Congress. Sponsored by the school of nursing and alumni association, University of Toronto. June 19-20: tours in Toronto and environs to be arranged at request of persons attending conference. Apply to the Secretary of the School, University of Toronto School of Nursing, 50 St. George St., Toronto 5.

June 22-28, 1969



International Council of Nurses' Quadrennial Congress, Montreal. Fee: before Jan. 22, $40; after Jan. 22, $60. Write to: ICN Congress Registration, 50 The Driveway, Ottawa 4, Ont.

August 8-10, 1969
Reunion of Moncton Hospital School of Nursing Alumnae, New Brunswick. Members of all classes, 1909-1969, welcome. Write to: Alumnae Reunion Committee, c/o The Moncton Hospital, Moncton, N.B. □

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By SUE RODWELL WILLIAMS, M.R.Ed., M.P.R., Instructor in Nutrition and Clinical Dietetics, Kaiser Foundation School of Nursing; Nutritional Consultant and Program Coordinator, Health Education Research Center, Permanente Medical Group, Oakland, Calif. Publication date: February, 1969. Approx. 672 pages, 7"x 10", 117 illustrations, including original drawings by George Straus. About $9.75.



Fig. 12-8. Research in food chemistry. A chemist in the U.S. Department of Agriculture's Agricultural Research Service makes an adjustment on a molecular still used in a project to aid in the manufacture of dry milk. (USDA photograph.)

A completely up-to-date, comprehensive, and authoritative new text that includes such outstanding features as:

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Medaseptic D has a catheter tip with a tip protector. Materials used to produce both the bulb and syringe are inert and will not affect the fluids they touch. Shatterproof polypropylene is used in the production of the unit's barrel.

Further information is available from Baxter Laboratories of Canada, Limited, 6405 Northam Drive, Malton, Ont.

Publication Available

A recently published booklet entitled *Highlights of a Study on Single-Unit Drug Dispensing* gives highlights of an Owens-Illinois survey on single-unit drug dispensing in hospitals, which was completed in early 1968.

Single-unit drug distribution is a system of packaging drugs in individual doses ready to administer to the patient.

Among advantages of dispensing of drugs in unit doses are: possible reduction of medication errors; more efficient administration of medications and utilization of hospital personnel; better inventory control; and better cost accounting.

Findings of the study have prompted Owens-Illinois to develop a unit-dose packaging system.

Marketed under the trade name Uni-Pak, the system consists of amber vials in two sizes, aluminum convenience closures, cappers, and hinged plastic boxes for packaging medications.

Further information may be obtained from Owens-Illinois, Toledo, Ohio 43601.

Gyn-Aid

Gyn-Aid is a new medical device for keeping a patient's legs spread apart during an examination in which the lithotomy position is required, such as pelvic, rectal, or urological examination, or minor surgery.

Designed by a gynecologist, Gyn-Aid saves the physician's time and allows the patient to relax. Slight pressure inward by the thighs holds the Gyn-Aid in place without strain.

Gyn-Aid is manufactured of strong plastic, which is unbreakable with normal use. As it is applied over the drape sheet, frequent cleaning is not required.

Further information may be obtained from Custom Products Company, 2614 N. Seaman Ave., El Monte, California 91733.

Climestrone Tablets

Climestrone Tablets are the water-soluble conjugated form of estrogens, extracted from natural sources (equine) and standardized with the addition of sodium estrone sulfate.

These tablets are indicated in the treatment of menopausal symptoms; postmenopausal osteoporosis; to supplement declining estrogen levels in the postmenopausal female; functional uterine bleeding; postpartum breast engorgement and other conditions associated with insufficient endogenous estrogen.

Cyclic therapy (a 3-week regimen followed by a 7-day rest period) is recommended to avoid continuous stimulation of breast and uterus.

Full information is available from Charles E. Frosst & Co., P.O. Box 247, Montreal 3.



Plastazote

Plastazote, a new thermoplastic splinting material, is made of foamed, very light polyethylene. It is molded directly on the patient's body. Plastazote is nontoxic, unaffected by acids and alkalies, and can be kept clean by washing with hot water and detergents.

Plastazote, used with or without reinforcement by lamination, is supplied in perforated sheets in one-quarter to one-inch thicknesses. It is prepared in a thermostatic oven at 140°C. for a minimum of five minutes. It is then applied to the patient and molded to his exact shape. After about 20 seconds, as it cools, it begins to set.

In addition to limb and body supports, Plastozote has extensive application in the orthopedic footwear field, providing insoles that give immediate relief to the patient.

For further information write to the Medical Division, Smith & Nephew Ltd., 2100 - 52nd Ave., Lachine, Que.

new products



Miniset

This new vein infusion set, called Miniset, is useful for infusing either intravenous solutions of blood to restless patients, infants, or patients with fragile, rolling veins.

The new set features a slim, one-piece design which permits the needle to be held close and flat against the skin. Soft and flexible security wings on the needle permit a firm grip for controlled needle placement. When taped flat against the skin, these security wings assure conformation to skin contours.

Miniset also contains a short, thin-wall, stainless needle, which provides greater fluid flow, even with smaller gauges.

The Miniset's flexible tube, security wings, and short needle reduce the possibility of pressure necrosis or phlebitis.

Further information is available from Baxter Laboratories of Canada, Limited, 6405 Northam Dr., Malton, Ont.



Nourishment Station With Microwave Oven

This microwave and nourishment station is a self-contained work station which provides all facilities for service of regular meals, between meal nourishment, and special diets.

Patients trays can be prepared in the central kitchen and wheeled directly into the microwave and nourishment station's holding refrigerator. Food to be heated is removed from the holding refrigerator and placed in the microwave oven unit. The patient is served directly from the microwave oven, which insures that the food is hot and attractive.

The station also includes two hot plates (one with thermal eye), an automatic coffee maker with 60-cup-per-hour capacity, and an ice dispensing unit which makes, stores, and dispenses sanitary ice directly into the patient's container.

Other facilities include: dry storage area with adjustable shelves, utility drawer; tilt-out removable waste receptacle; counter space; large stainless steel sink with soap dispenser and hot and cold water faucets; paper towel dispenser; counterlevel and overhead fluorescent lights, and two three-prong electrical outlets.

Write to the Market Forge Co, 35 Garvey St., Everett, Mass. for a descriptive brochure.



Transport Seat

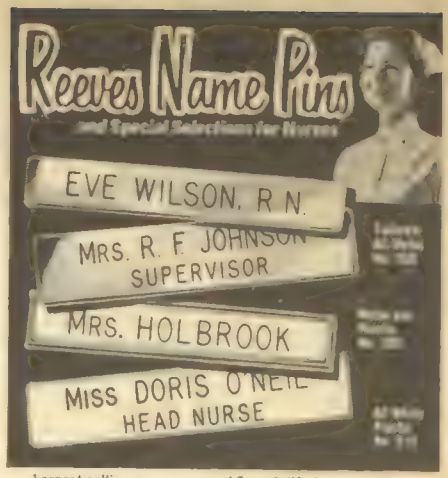
This transport seat is ideal for carrying a patient short distances in crowded areas. The seat may remain under the patient during airplane trips or while he is in the wheelchair. Straps over the attendant's shoulders help distribute the patient's weight. The straps may be removed when not in use. The transport seat is excellent for moving invalids on and off airplanes or other vehicles.

Address inquiries to: Posey Products stocked in Canada, B.C. Hollingshead Ltd., 64 Gerrard St. E., Toronto 2.

Actified-A

Actifed-A is indicated for the relief of congestion, aches, pain, and fever associated with colds and sinusitis. It is an orally effective potentiated combination of "Sudafed" (decongestant), Actidil (high potency antihistamine) and acetaminophen (effective analgesic and antipyretic).

For further information: Burroughs Wellcome & Company (Canada) Limited, 60 Riverview Ave., LaSalle, P.Q.



Largest-selling among nurses! Superb lifetime quality . . . smooth rounded edges . . . featherweight, lies flat . . . deeply engraved and lacquered. Snow white plastic will not yellow. Satisfaction guaranteed. GROUP DISCOUNTS.

SAVE: Order 2 identical Pins as precaution against loss, less changing		With 1 line	With 2 lines
ALL METAL ... No. 100	1 Pin only	1.40*	1.70*
	2 identical	2.25*	2.85*
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*IMPORTANT Please add 25c per order handling charge on all orders of 3 pins or less. GROUP DISCOUNTS 25-99 pins 5% 100 or more 10%

Remove and refasten cap band instantly for laundering or replacement. Tiny molded black plastic tac dainty gold Caduceus. 6 Tacs Per Set

Cap-Tacs No. 200 6 Cap Tacs only $1

SPECIAL! 12 Sets (60 Tacs) $9. total

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World famous Cross writing instruments with Sculptured Caduceus Emblem. Lifetime guarantee

	12 Kt. GOLD FILLED	STREAMLINE CHROME
Pencil	No. 6603 $8.00	No. 3503 $5.00
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6" professional precision shears forged in steel. Guaranteed to stay sharp 2 years

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SPECIAL! 1 Doz. Shears $20. total
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Fine imported pigskin, regular bill divider, coin pocket, compartment for currency, clear key shield, etc. With gold stamped Caduceus or plain. Choice of Red or Blue.

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TO: REEVES COMPANY, Attleboro, Mass. 02703 U.S.A.

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PIN LETTERING.....

2nd Line

INITIALS (Where ordered).....

I enclose $ (Mass. residents add 3% S.T.)

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in a capsule

A heart of rubber

Hearts of rubber may some day be added to the crooner's tunes about hearts of gold and hearts of stone. The Goodyear Tire & Rubber Company is busy developing an artificial heart made of natural rubber and polyurethane. It has kept sheep and calves alive as long as 50 hours. The researchers hope that by 1970 the rubber heart can be used to keep people alive until a human heart becomes available for transplant.

The tire company is working in cooperation with medical research teams at the Cleveland (Ohio) Clinic and the University of Utah. Goodyear spokesmen say that rubber resembles human tissue more closely than any other substance. It expands and contracts much like natural tissue and will do so in rhythm with the artery to which it is joined.

The rubber heart can pump two gallons of blood a minute. It is powered by an external source of air power but, in future, may be powered by portable nuclear reactors.

Jim Wright, Goodyear's man with many hearts, to date has built more than 30 rubber hearts.

The enigmatic sex

Men – cheapskates and spendthrifts, fickle and faithful, aggressive and timid, possessive and protective, Casanovas, perfectionists, narcissists, egoists, playboys, and bores.

They're all in *L'homme cet animal rétif,* which literally translated means "man – this restive animal." "Rétif," however, is an elusive word; its meaning lies somewhere among obstinate, unmanageable, unpredictable, and incomprehensible. In short, it says the same thing about men that men have been saying about women for centuries – they're impossible to pin down and impossible to understand.

L'homme cet animal rétif, is co-authored by Colette Gagnon, a federal government translator, and Agathe Legault, assistant editor of *L'infirmière canadienne.* It's the product of consultations with clairvoyants, schoolmarms, graven images, lovers, beautiful people, hypocrites, hearts of stone, separatists, executives, Romeos, rigolos, gigolos, robots, aristocrats, mama's boys, career women, Ophelias, guardian angels – and others.

If you're the last bit serious about brushing up your French, reading this book may be the most enjoyable method you've discovered in a long time. A person who speaks French fluently would spend one or two hours chuckling over the foibles of men bared in this book. If your French is anything less than fluent, you'll spend longer, but the diverting cartoons and casual style will beguile you into spending the time to decipher Mlle Legault's and Mlle Gagnon's witty and penetrating remarks about that lovable yet infuriating sex.

It's published by Lidec Inc., 1083 Van Horne Avenue, Montréal 154, and sells in Canada for two dollars.



"I hope I'm not getting too personal, but how do you get these sheets so white?"

A very special place

"For business or pleasure, stay at Toronto's ***, a *very* special place. It's like a few days in Rome . . . or Paris . . . or even swinging London town. The *** can turn a business trip into a relaxing time. Dine, dance, or stay awhile at Toronto's ***, a *very* special place."

So goes the ad, murmured over the air in liquid, seductive tones. It seems that certain Ontario nurses succumb to the insidious presence of the media, because they recently staged a four-day conference at the hotel in question.

It's too bad, though, that they didn't check the price list. Or if those who planned the conference did, it's regrettable that the rank and file nurse who attended the conference wasn't given a sneak preview of incurrable expenses.

If Nurse Patricia likes an abstemious, Continental breakfast of juice, rolls and coffee, she must be prepared to be relieved of $1.75. If she's used to hearty English breakfasts of juice, cereal, bacon and eggs, toast and coffee, she'll have to dig into her pocket to the tune of $3.25. Not to mention tips.

Did you know that substantial breakfast of fresh orange juice, ham and eggs, toast and coffee can be had at Oscar's, New York's Waldorf Astoria's breakfast nook, for two dollars? But then that's expensive American money.

A lot of nurses lost a number of pounds during that conference. They went on the cheap at breakfast, skipped lunch, and dined on $3.25 omelets for dinner (no coffee). They would have sneaked elsewhere for meals if their sleeping accommodation hadn't been an island paradise with taxi service only, to the finer spots in the heart of the city.

No wonder nurses are agitating for higher salaries.

Fix Bozo sick leg

Were *you* upset when you noticed Bozo's missing foot in the December mini-editorial? The presses rolled to a dead stop when our efficient liaison with the printer noticed this glaring "error" in the artwork!



Who Prefers GOMCO®

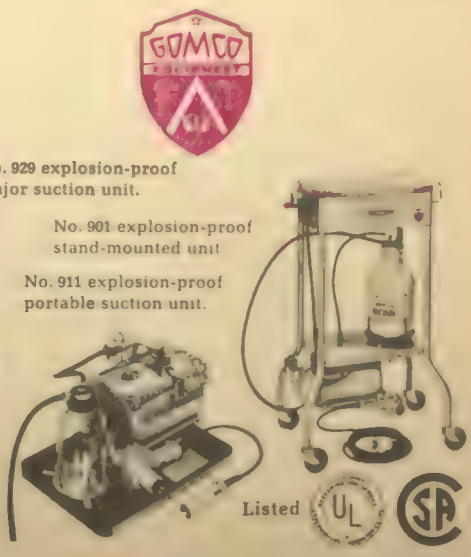
explosion-proof suction units?

"We do," say most O. R. nurses.

Here's why:

Gomco Explosion-Proof Suction Pumps are ready for life-protecting service because of their dependable, quiet operating pump, precision regulating valve and gauge, explosion-proof, heavy-duty motor and sealed-in switch. Cabinet, portable, and stand-mounted units.

Are your operating rooms properly equipped with Gomco? For latest catalog, see your dealer or write: GOMCO SURGICAL MANUFACTURING CORP., 828 E. Ferry St., Buffalo, N.Y. 14211



No. 929 explosion-proof major suction unit.

No. 901 explosion-proof stand-mounted unit

No. 911 explosion-proof portable suction unit.

Listed UL CSA

Countdown to Congress

During 1968 the message in nursing journals all over the world has been "Come to Canada for ICN Congress 1969." Here's what nurses in other countries have been reading about us.

Loral Graham



If they can make it, you can make it

In the past year, Canada, Canadians, and Canadian nurses have received impressive coverage in the nursing journals of the world. Nurses all over the world know that Canadian nurses will be hostesses for the largest Congress in the history of the International Council of Nurses. They have been told that Canada is a country as wide as the distance between Stockholm and Bombay; that it is a country with a distinct international flavor, and that Canadians move easily and readily in international circles. And they've been assured of one thing more: a cheerful, warm, welcome from the Canadian Nurses' Association and its 80,000 members.

The *Irish Nurses' Journal*, a pocket-sized magazine, devoted seven-and-one-half pages of the 20 pages of its August issue to ICN and the 1969 Congress. The editorial, although not specifically about ICN, was entitled "Focus on the Future," the theme of the Congress. An article by Martha G. Shout, Nurse Adviser to the

Mrs. Graham is Assistant Editor of THE CANADIAN NURSE.

ICN, outlined the history of ICN and its contribution to the 20th century. A full-page "Nursing in Canada Statistical Survey" told Irish nurses how many nurses there are in Canada, where they work, and where they were educated.

Australian nurses have been saving their money since August 1967 when they were first informed in *The Australian Nurses' Journal* that they could combine six- to eight-week world tours with their visit to Montreal in June 1969. Their tours will include visits to intriguing places like Bangkok, Acapulco, Papeete, Nandi, Beirut – and Vancouver. Belgian nurses, too, have been offered package-deal tours, but their tours will be centered in North America. Canadian points of interest on their itinerary include Ottawa, Toronto, and Niagara Falls; the remainder of their time will be spent in the United States seeing nature's wonders in the Grand Canyon, trying to resist the slot machines in Las Vegas, breathing smog in Los Angeles, and craning their necks in New York City.

Other national nursing magazines have corresponded with the Canadian Government Travel Bureau and the National Film Board to give their nurses a glimpse of some of the more spectacular or colorful aspects of Canada's geography and history. Danish nurses have paused to look at the postcard favorite, Maligne Lake in Jasper National Park; a rare closeup of curly-horned mountain sheep also in Jasper National Park; and one of the classic photographs taken in the Yukon Territory in the 1890's showing a string of prospectors in overalls, braces, and floppy wide-brimmed hats mucking for gold in a long, wooden sluice.

In their national nursing magazine, French nurses have had an apportunity to view a photo of "un spectacle qui vous coupe le souffle" – the Maid of the Mist, Niagara Falls. They may also know a little more than most Canadians do about Jeanne Mance, thanks to a photo of her statue in Quebec City and an article by a doctor from Langres, France about her life of service to the sick in 17th century French Canada.

The Netherlands *Jaarboekje 1968* displayed an imaginative, colorful cover on which a map of the Netherlands, a symbol of the Dutch nursing organization, and a globe representing the International Council of Nurses, were linked by rays of the sun. *The Philippine Journal of Nursing* printed an article about the Congress in a section entitled "Around the World in Nursing," illustrated with sketches of a nurse reading a newspaper, and a globe. *The Nigerian Nurse* entitled a reprint of the program of the Congress "Countdown to Montreal."

Since March 1968, the monthly *Nursing Journal of India* has printed five articles about Canada and nursing in Canada. *The Jamaican Nurse,* a colorful journal with a black and orange cover, devoted three pages of its April-May issue to Canada and the Congress. German nurses, in *Deutsche Schwestern Zeitung* have had an opportunity to read a history of nursing in Canada from its beginnings in Quebec City, as well as articles on nursing education in Canada by CNA's consultants in nursing education, Margaret Stees and Shirley Good.

The award for the most engaging copy concerning the ICN Congress must, however, go to the *Japanese Journal of Nursing Kango*. According to the typed insert stapled onto the inside front cover, an "Invitation of the Applicants to the 14th ICN Convention" can be found on page 101. Sure enough, on page 101 is a neat half-page boxed item complete with title in bold type. Otherwise, to my uninitiated eye, it is a decorative display of Japanese characters. Scrutinizing it a little more closely, however, I found the significant arabic letters 14, 1969, and ICN buried among the artful symbols.

The *Hellenic Nurse* ran an equally intimidating page of script on the 1969 Congress but had the mercy to head it with a bilingual (French and English) symbol of ICN '69. *The Journal of Nursing* published by the Nurses' Association of the Republic of China was even more benevolent to Western and, in particular, English-speaking readers. This magazine printed an entire page in English – the complete program of the Congress. One can scarcely quibble over typographical slipups such as "poasbesic" for "postbasic". The mind boggles over the problems of setting even one line in Chinese in the magazine you are now reading!

All smiles aside, the message that nursing journals all over the world have been relaying to their readers is capsulized in the nurses' journal of Colombia: "Bienvenida al Canadá." If *they* can make it *you* can make it – see you there! □

The value of revascularization surgery

Revascularization procedures offer an excellent chance of a good result in 98 percent of patients with coronary artery insufficiency.

Arthur Vineberg, M.D.

Throughout the past 23 years of experimental and clinical attempts to increase the oxygenated blood supply to ischemic myocardium, surgeons have been guided by the following generally accepted facts:

1. Coronary atherosclerosis involves the coronary arteries in their epicardial courses.
2. The disease is diffuse and progressive, gradually involving main stem and surface branches of the coronary vessels.
3. The arterioles lying within the myocardia of the right and left ventricles are disease-free except in severe diabetic and hypertensive patients. There are three main arteriolar zones, namely, those supplied by the right, anterior descending, and circumflex coronary arteries respectively.
4. The heart muscle contains large, lake-like vascular spaces (myocardial sinusoids) lying between muscle bundles into which extra coronary oxygenated blood can be introduced without formation of hematoma.

Based on these facts, all our revascularization efforts have aimed at introducing new sources of oxygenated blood deep in the left ventricular myocardium and, more recently, into the right ventricular myocardium. It has been our aim to revascularize the entire heart through the coronary arteriolar networks, which are normally supplied by the diseased coronary arteries. This has been accomplished by introducing multiple sources of extra cardiac blood and by uniting separate arteriolar zones so that all arterial blood entering the heart muscle is distributed throughout the entire heart.

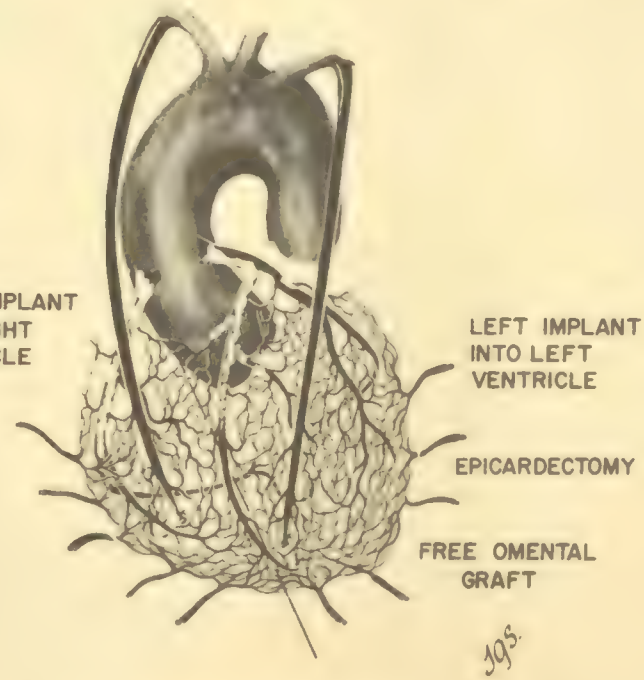
To this end, the left internal mammary was implanted into the left ventricular wall in 1945 in the experimental animal. During the succeeding five years, we learned that an internal mammary artery implanted into the left ventricle of a normal dog's heart would remain patent for years, providing it was implanted deep in the interior wall. It started to bud in 12 days and formed true, arterial branches that joined surrounding intramyocardial arterioles between the third and sixth week. When the anterior descending and circumflex coronary arteries were narrowed at their origins in the experimental animal by ameroid constrictors, the implanted internal mammary artery formed anastomoses with the arterioles of the entire left ventricle at the end of six months or longer; there were never communications with the right coronary system.

Tri-arteriolar zones

There are three areas in the left ventricle where the terminal branches of all three coronary arteries end. I have termed these tri-arteriolar zones. Theoretically, an implanted internal mammary artery placed into one of the tri-arteriolar zones is capable of

Dr. Vineberg is a former associate professor of surgery at McGill University, Montreal, and is now senior cardiac surgeon at The Royal Victoria Hospital, Montreal.

REVASCULARIZATION OF ENTIRE HEART BY RIGHT AND LEFT VENTRICULAR IMPLANTS, EPICARDIECTOMY WITH BLOODLESS OMENTAL GRAFT. VINEBERG.



THESE OPERATIVE PROCEDURES CONVERT HEART INTO ONE LARGE ARTERIOLAR NETWORK AND ARE EFFECTIVE REGARDLESS OF THE TYPE OF CORONARY CIRCULATION OR LOCATION OF ISCHEMIA.

revascularizing the entire heart. The first of these is on the interior surface of the left ventricle near the apex. It is here that whenever possible single implants have been placed in human hearts.

The second tri-arteriolar zone lies more laterally near the junction of the diaphragmatic and lateral surface of the left ventricle. This zone has been implanted accidentally in the past and deliberately since October 1967. Arteries lying in both of the above-mentioned zones have been examined by injection studies from 3-1/2 to 17-1/2 years after implantation and have frequently been shown to fill all three coronary arteries retrograde to points of coronary occlusion.

The third tri-arteriolar zone lies high up on the posterior wall of the left ventricle in its inner one-third, making access to this zone technically difficult.

I believe it is better to leave the patient's own arteries alone and to provide multiple, large and small by-passes that do not block throughout the years.

If placed in the inner half of the left ventricular wall, internal mammary arteries implanted into the myocardium will remain open even though there is no myocardial ischemia. This is because the artery is surrounded by arterioles with diastolic pressures of 40 mm. Hg, as compared with the diastolic pressure of 80 mm. Hg within the implanted internal mammary artery itself. It has always been our objective to connect with the arterioles in the myocardium, not, as has been suggested by some, with the surface vessels.

To remain open, a superficially implanted vessel requires a markedly diseased superficial vessel so that there will be a pressure differential between the two vessels. Operations that attempt to connect with the surface vessels are not in accordance with the principle of myocardial revascularization that we have enunciated and followed since 1950. The coronary vessels in their epicardial courses become diseased. In time, implanted internal mammary arteries primarily communicating with such vessels will be more likely to block off than if they were deeply implanted, connecting with intra-myocardial arterioles, such as has been experienced with grafts in peripheral vascular surgery.

Implant in man

In 1950, the first internal mammary artery implant was performed on a man, placing the artery in the anterior wall of the left ventricle. Since that time, many hundreds of patients have undergone the single internal mammary artery implantation for relief of myocardial ischemia due to coronary artery insufficiency, with less than two percent operative mortality and an overall 80 percent improvement. Clinical experience clearly indicated that the internal mammary artery, after implantation, took at least nine months to function. For this reason, patients with angina decubitus did badly when the internal mammary artery alone was implanted.

Accordingly, in 1956 I stopped doing single internal mammary artery implantation operations in patients with angina decubitus or chronic left ventricular failure and did not operate on such patients until December 1962, when the supplementary procedure of free

omental graft had been fully tested in the laboratory.

There have been many critics of the internal mammary artery implant procedure. At first it was called a string-like artery that always blocked. This, of course, is not true. I have patients who have been operated on and studied up to 17-1/2 years after internal mammary artery implantation. Many of these patients have died from other causes, such as fights, cancer, pneumonia, and meningitis.

A total of 42 patients were examined at autopsy and injection of the internal mammary artery with Schlesinger mass, which does not penetrate anything smaller than an arteriole, filled the entire coronary circulation. Thirty-eight of the 42 patients (88 percent) studied many years after surgery had fully patent internal mammary arteries with extensive mammary coronary anastomoses. Four of these patients were examined 3-1/2, 4, 12-1/2 and 17-1/2 years after internal mammary arterial implantation. All their coronary arteries were blocked at their origins and the internal mammary artery was the only artery in the heart. Twenty-two patients underwent coronary arteriographic studies of the internal mammary artery for 6 months to 12-1/2 years after surgery. Seventeen of these (77 percent) showed good mammary-coronary anastomoses. Of the 64 patients studied, either by pathology or by cine angiography, 54 patients (84 percent) had fully patent internal mammary arteries that formed mammary-coronary anastomoses with the surrounding arterioles.

Free omental graft

It became clear that the internal mammary artery only supplied the arteriolar zone into which it was implanted. For this reason, epicardiectomy was added to open collaterals between the anterior descending and the circumflex areas. Epicardiectomy of the left ventricle, however, does not open collaterals between the right and left coronary arteriolar systems. This has been accomplished by the free or bloodless omental graft.

After many years of experimentation, it was found that the free omental graft penetrates the wall of the aorta, the pericardium, and the epicardium covering the coronary arteries to obtain arterial blood for itself. When the bloodless omental graft is thus interposed between the pericardium and heart, it obtains oxygenated blood on both its surfaces by forming arteriolar communications between its own vessels and the pericardial vessels and those of the aorta and diaphragm. This oxygenated blood flows from high to low pressures and thus from extra cardiac sources into omental vessels and thence into the coronary systems.

Removal of the epicardium assists the graft to form its communications with the heart, arteries, and arterioles. Such a graft distributes oxygenated blood from right to left or left to right coronary systems, as well as adding another extra source of oxygenated blood to the ischemic myocardium. When combined with implantation of left internal mammary artery into left ventricular wall, patients with angina decubitus can be safely operated on with good results. Likewise, patients with chronic left ventricular failure have had their chronic left ventricular failure reversed. Over 200 patients have undergone the combined operation of left internal mammary artery implantation, epicardiectomy, and free omental graft. For those patients who have no angina at rest, the operative mortality has been under 4 percent, with an overall 90 percent improvement.

The free omental graft as a revascularization procedure has a long, documented, experimental background. In addition, it has been used clinically for nearly six years. We now have clinical evidence of its viability in both living patients and in patients who have died from strokes and other causes, up to four and three-quarter years. Not only has there been viable omentum, but the vessels within the omentum have been shown, through Schlesinger mass injections, to be in full communication with the coronary arterial system and the arterial network in the mediastinum.

When the free omental graft fails to live, it is because proper epicardiectomy and sero-pericardiectomy have not been carried out, nor has the omental graft been fixed by multiple sutures to the heart and to the aorta. Like the original internal mammary artery, this valuable operative procedure is under criticism and will continue to be so until it is used properly.

With the addition of the right internal mammary artery implanted into the right ventricular wall, there has been no operative mortality and no late mortality up to two and one-half years. This includes seven patients who had angina decubitus at the time of surgery.

Type of patient

It should be made clear in reporting results, what type of patient is operated upon. In our own series, 75 percent of the patients have had from 1 to 6 myocardial infarctions 25 percent have had left ventricular failure, and 27 percent have had left ventricular hypertrophy. There has been reversal of left ventricular failure in 65 percent of the patients operated upon who suffered chronic left ventricular failure at the time of operation, and 80 to 90 percent of the patients have no pain, slight pain, or less pain.

It is also important to know the condition of the left ventricle with regard to function, size, and distribution of scar. In the many series of cases reported by others, it is quite clear that the majority of patients have had minimal or no myocardial infarctions at the time of surgery and few, if any, have chronic left ventricular failure. This is obvious as it is impossible to place two internal mammary arteries into the left ventricular wall when there is a good sized scar in either the anterior or posterior walls or in both walls of the left ventricle.

It is likewise important to know where the points of occlusion are located in the coronary arteries, particularly if they are in the main stems or wherever they are more distal. Results will vary greatly when the occlusion in the coronary artery is 3 to 4 cm. away from the origin and not at the origin.

Evaluation

Evaluation of postoperative results must include the evaluation of the clinical condition of the patient. It cannot be entirely cine angiographic evidence of the relief of a localized perfusion deficit. The relief of anginal pain, the correction of chronic ventricular failure, and the ability of the patient to return to his or her former occupation are also important.

In evaluation of the results of surgery, cine angiographic evidence of patent internal mammary artery or arteries showing that extra cardiac blood is reaching the heart muscle is of great value, but it does not supply the proof that the patient has been relieved of his symptoms. Surgeons like myself, who, in addition to implanting one or two arteries, are supplementing the procedure with epicardium and free omental graft find it impossible to outline by cine coronary arteriography the multitudinous small arterioles that deliver blood to the ischemic heart via the free omental graft.

Limitations

With usage, certain limitations have become apparent.

Limitations of Left, Internal Mammary

Artery Implantation into Left Ventricular Wall.

1. Damaged left internal mammary artery from other chest injuries. Rare.
2. Previous ligations of internal mammary arteries at the second inter-space. Rare.
3. Damage due to extensive pleuritis. Extremely rare.
4. Atherosclerosis of left subclavian artery at point of origin of internal mammary artery. Rare.
5. Hypertrophy of left ventricle. An implanted artery, even though it remains open, is too small to supply a large muscle mass alone. Two implants plus epicardiectomy and free omental graft are ideal.
6. Diffusely streaky, scarred left ventricle. Implanted internal mammary arteries in such ventricles have no run-off and few arterioles for its branches to anastomose with.
7. Thin-walled, left ventricles, caused by myocardial ischemia, are difficult to implant. Some have been implanted successfully.

Limitations of Epicardiectomy

1. Obliterative pericarditis from myocardial infarction or previous operation. Rare.
2. Extensive sub-epicardial fat deposits.
3. Diffuse intermittent scar.

Limitation of Free Omental Graft Applied to Omental Surface

The greater omentum itself may be absent (gastrectomy) or scarred (peritonitis) or damaged from previous operations. In the latter situation, the lesser omentum is used.

Limitations of Multiple Internal Mammary Artery Implantations

1. Thin, fat, or scarred anterior wall of the right ventricle, making right internal mammary artery implantation into right ventricular wall hazardous or impossible. Rare.
2. Extensively scarred anterior or posterior walls of the left ventricle permit left internal mammary artery implantation only. Usually, there is not enough good muscle in such ventricles to accept more than one artery.

Limitations of Gastro-Epiploic Artery Implantation

Unlike the internal mammary artery, the gastro-epiploic artery is frequently atherosclerotic. In addition, it cannot be implanted into the left ventricular posterior wall if this is scarred or is not long enough to go laterally.

Limitations of Segmental Resection, Patch-Graft or Arterialization By Vein Graft

A small percentage of patients have segmental disease. In the majority of cases, the disease is diffuse.

The principle of treating localized obstruction in the surface arteries is wrong, if long duration of relief from myocardial ischemia is expected. As coronary artery disease progresses, obstructions may occur distal to the point of the localized area of arterotomy. These will lead to a reduction of flow and eventual occlusion in the segmentally treated area.

Recently, surgeons at one of the clinics that had performed a large series of segmental patch-grafts indicated that they were no longer doing this type of operation because 29 percent of their patch-grafts had blocked and 13 percent had become narrowed. In other words, 42 percent were not functioning satisfactorily. These surgeons have suggested, instead, a vein replacement graft. There is no evidence to suggest that the arterioles in the myocardium become diseased, nor is there any evidence that the internal mammary artery implanted within the arteriolar network develops atherosclerosis.

The various operations that we have developed and have listed along with some others, with their limitations, is our reason for constantly searching for additional techniques of myocardial revascularization to supplement the internal mammary artery implant procedure. However, the combined operations of left internal mammary artery into left ventricular wall alone, or in combination with right internal mammary artery into right ventricular wall, epicardiectomy and free omental graft, can be used for total cardiac revascularization in practically all patients, as one can see from the foregoing list of limitations. There are many centers claiming to perform our operations, but they are not following techniques that I have proven to be of value.

Intramyocardial Omental Strip Implant

This operation is our most recent addition to our revascularization procedures. In this procedure the great omentum, after its removal from the colon, is laid upon a piece of plate glass and three strips of omentum containing one or two blood vessels are cut out one-half inch wide in such a way that the upper end of the strip communicates with a wide and fan-shaped piece of omentum containing numerous vessels. The fan-shaped piece of omentum is wrapped around the ascending aorta and the narrow tails are threaded through the left and right ventricular walls, both anteriorly and posteriorly. This operation has proven to be of value in maintaining the life of an animal with triple ameroid coronary artery occlusion.

The intramyocardial portion of the omental strip forms arteriolar communications with the arterioles of the myocardium within eight days, and the portion around the aorta does likewise by tapping the aortic wall so that the aortic blood flows into the ventricular myocardium within eight days.

Since an implanted omental strip graft, unlike an implanted internal mammary artery, requires no run-off, but actively attaches itself to any arteriole in its vicinity, taps the aorta, and conveys oxygenated blood from high to low pressure areas in the myocardium, this operation is planned for the treatment of large, intermittently scarred left ventricles in failure, in combination with resection of large anterior and/or posterior scars. The omental strip implant is still experimental and will not be applied by us in the treatment of the large heart in heart failure until it has been more thoroughly tested in the laboratory. It is in the third year of experimental testing. It may be the answer to the intermittently diffusely scarred large heart.

We have not developed new revascularization procedures because of dissatisfaction with our original internal mammary artery implant, but rather to support this procedure and for use when the heart pathology makes a systemic artery implant unlikely to succeed. As long as 30 percent or more of the left ventricular muscle mass remains, revascularization has a chance to work. Many patients with large hearts upon which I have operated are still alive; others have lived from two to four and three-quarter years after surgery, many with marked improvement.

Until such time as the rejection phenomenon has been solved, a combination of revascularization procedures with or without local excision of large left ventricular scars must be given serious consideration for all large hearts before heart transplantation is considered. Revascularization procedures, either direct or indirect, offer an excellent chance of a good result in 98 percent of patients with coronary artery insufficiency. □

Advances in surgery for coronary artery disease

A summary of some of the major developments in cardiovascular surgery and a glimpse at possible advances in the future.

A.S. Trimble, M.D., B.Sc. (Med.), F.R.C.S. (C), F.A.C.S.

Arteriosclerotic coronary artery disease is the commonest cause of cardiac disability and death in Canada and the United States. Although the surgical management of the chronic form of this condition has now become commonplace, this was not so eight years ago. Indications, methods of investigation, and surgical techniques have changed during that period. This review will summarize some of the major advances in the field and briefly describe the latest developments in treating the acute form of heart attack.

History

The pioneering research of O'Shaughnessy[1] and Vineberg[2,3] laid the experimental foundation for revascularization of the myocardium. Dr. Vineberg's animal and clinical work proved that a bleeding internal mammary artery drawn into a tunnel in the left ventricular myocardium would develop collateral flow to the heart's own coronary arteries. This flow supplied by the implanted mammary vessel was adequate to prevent death in animals when the coronary artery was ligated and, in humans, led to relief of angina pectoris.

Despite this remarkable work there was little enthusiasm for the technique and only limited clinical application. There were two major reasons for this. The vagaries of the symptom, angina, were well recognized and often placebos or minor surgical techniques, such as sympathectomy, led to improvement in some cases. Also, the demonstration of a patent artery had not been done in the living, but shown by injection at autopsy.

Early in the 1960s, two major developments led to a complete change in the attitude of the medical profession. At the Cleveland Clinic, Sones[4] developed the technique of selective coronary cineangiography. This involved the passage of a catheter up the brachial or femoral artery and its insertion into the coronary artery. Dye was then injected and high speed radiographs taken to outline the lumen of the vessel. Organic occlusions and stenoses in each coronary artery could thus be documented accurately and related to symptomatology. Later, these same techniques were utilized to show patency and collateral flow from the injected internal mammary artery. This flow could be correlated to symptomatic improvement in the living, and thus a scientific means of evaluating the procedure was at hand. Sophisticated engineering developments of cineangiography, such as videotape and instant replay, have since been applied.

The other major contribution was the long-term follow-up of some 30 patients by Bigelow at al.[5,6,7] These doctors utilized the Sones' method to correlate symptomatic improvement and internal mammary patency in patients as long as 13 years after operation. Their presentation finally led to wide general clinical application of the internal mammary or Vineberg revascularization operation.

Indications and contraindications

Angina on effort, or with emotion, which interferes with the patient's ability to work or enjoy life, has been the prime indication for operation. Usually a trial of medical therapy is undertaken first. Results to date suggest that less disabled patients will be offered the benefits of the operation in future. Long-term follow-up will eventually justify the decision to make this a form of prophylactic surgery in the asymptomatic individual who has had a heart attack.

Patients over the age of 60 and young patients, who usually have a severe family history of the disease are considered less suitable. Gross obesity, a recent coronary occlusion and congestive failure are contraindications.

Investigations

The routine history, physical examination, chest x-ray and electrocardiogram are followed by two special tests. An exercise test, walking on a treadmill, documents the appearance of angina after a certain distance. At this time an electrocardiogram is taken and compared to one taken while the patient was at rest. Changes indicating

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cardiac ischemia are often shown, suggestive evidence that the pain is related to organic disease. Then a selective coronary cineangiogram, previously described, is carried out.

This catheterization study documents the extent of the disease in the major coronary arteries and their branches. In addition, dye is injected into the left ventricular cavity to assess the efficiency of left ventricular contraction. This has proven to be a most important criterion for acceptance for operation.

Patients demonstrating a moderate to marked reduction in systolic contraction, that is, the scarring has been so diffuse in the myocardium that little normal muscle remains, are usually denied the procedure. The risk is high and the chances for symptomatic improvement slight. The catheterization procedure, although entailing a small risk, is thus essential for proper patient evaluation.

Two basic operative procedures are now available in chronic/arteriosclerotic coronary artery disease: revascularization and direct coronary artery surgery.

Revascularization procedure

At the Toronto General Hospital, the technique most commonly used is similar to that originally described by Vineberg.[2,3,5] The fifth interspace is entered through a left anterolateral thoracotomy. The fifth costal cartilage is divided prior to insertion of the rib spreader to prevent traction on the internal mammary artery and subsequent spasm. The artery is then carefully dissected, dividing the intercostal branches between silver clips, and including in the pedicle the accompanying vein and some periadvential tissue. At the level of the sixth interspace it bisects and at this level is divided. The dissection is then carried proximally to the second interspace. It is then wrapped in paparavine-soaked gauze to prevent spasm.

A window is created in the fibrous pericardium exposing the anterolateral surface of the left ventricle. A tunnel is made in the middle third of the myocardium, usually parallel to the left anterior descending coronary artery over a distance of 3 to 4 cm. Two or three clips are cut from side branches at the appropriate level in the internal mammary artery and, actively bleeding, it is drawn into the tunnel. The distal end is then secured with a suture.

Prior to the resection of fibrous pericardium, the pericardial fat pad is dissected off, retaining its superior pedicle. It is applied to the abraided epicardial surface of the left ventricle. The adhesions produced allow extra blood to enter through the pedicle and perhaps induce a more even distribution of blood to the ventricle.

Finally, a low stellate, high dorsal, left sympathectomy is done to prevent coronary artery spasm and possible myocardial infarction in the early postoperative period. The occurrence of this complication entails the major operative risk.

Variations

(a) *Site of the Tunnel:* There is, as yet, no proof that improved results are obtained if the artery is implanted in the area of ischemia — posterior or anterior. Some surgeons, however, prefer to create the tunnel in a site that prior electrocardiograph recordings and direct visual evidence suggest to be the worst area.

(b) *Bilateral Implants:* Using a sternum-splitting approach, both internal mammary arteries are dissected out as previously described.[8] The right is then inserted into a tunnel in the anterior wall of the left ventricle and the left mammary into the posterior wall. This operation entails a somewhat greater mortality and morbidity as compared to a single implant, but may be found to offer superior results once long-term follow-ups become available.

Results

Single internal mammary artery implantation entails an operative risk of two to three percent in properly selected cases.[5-9] The bilateral procedure has a slightly higher mortality. Follow-up studies show that 70 to 90 percent of patients are improved. This means that there is a major relief of angina — sometimes total — a reduction in medication, and resumption of a more normal existence.

Although not statistically proven, there is suggestive evidence that although the operation will not prevent a subsequent coronary thrombosis and myocardial infarct, it will make such an event less morbid and improve the chances of the patient surviving. It is for this reason alone that some centers may accept asymptomatic, post-infarct patients for operation. In most instances patient improvement can be correlated to a patent internal mammary implant, which, at cineangiography, demonstrates good collateral flow to the patient's own coronary arteries.

Direct coronary artery surgery

The majority of the patients catheterized at the Toronto General Hospital demonstrate tri-coronary artery disease — either occlusion or stenosis — of a varying degree. Some centers investigate less disabled patients and in some a localized block in the proximal portion of a single coronary artery is demonstrated. These centers have operated on a number of patients using coronary endarterectomy or bypass grafting.

(a) *Coronary Endarterectomy:* To date, the left coronary artery has not proven amenable to direct procedures for anatomical reasons. A growing experience is developing with such operations on the proximal right coronary artery. Endarterectomy, usually with vein-patch angioplasty, was originally attempted because of its known success in carotid and femoral arteries. It involves an enucleation of the atheromatous plaques over the area of stenosis or occlusion. The results published to date suggest an operative mortality of 20 to 25 percent, with 60 percent late improvement. Late occlusions demonstrated by cineangiography appeared common, however, and as a result the following procedure is being evaluated.

(b) *Bypass Grafting:* Saphenous vein

bypass grafts from the ascending aorta to the coronary artery distal to the occlusion are now being evaluated. As described above, these procedures have proven valuable in peripheral vascular surgery. Initial results suggest a lower mortality than endarterectomy and improved late results in coronary artery disease.

Acute coronary artery disease

Acute coronary occlusion leading to myocardial infarction — a heart attack — often leads to sudden death. A large number of patients, however, do live long enough to enter hospital and there die, either from ventricular arrhythmias or congestive failure. In this group, advance has been made in both curative and supportive techniques.

Curative

Over 15 years ago, Murray suggested that immediate resection of the dead muscle resulting from an acute coronary occlusion might lead to a higher survival rate.[10] Subsequently, Heimbecker documented in animal experiments that this procedure, infarctectomy, could lead to a high survival rate.[11] Human experience remains limited to date. The indications in patients appear to be irreversible arrhythmias or congestive failure.

Supportive

(a) *Non-Surgical:* The development of coronary units,[12] based on principles evolved in acute therapy units, has improved the survival rate from acute myocardial infarction. The advances include continuous electrocardiographic monitoring, respiratory support, and new drugs.

(b) *Mechanical:* A diverse number of mechanical supportive techniques have been devised and tested in animal experimentation. To date there has been limited clinical application. The various methods include artificial hearts, ventricular compression devices, counter pulsation, and partial bypass to mention a few. All have attributes and feasibility at least in the experimental laboratory. Many problems, however, arise from their use — including thrombosis, red cell and protein destruction, power source.

A great deal of research is now making inroads into these problems. The development of an effective artificial heart — either for total or parital support — or a heart-lung machine capable of functioning for long periods would appear to be necessary for any of these devices to prove functional.

Disabling coronary artery disease

Two conditions should be defined: ventricular aneurysm and the "end stage" cardiac, who cannot be improved by a revascularization procedure.

Ventricular aneurysm

This is an uncommon late complication of myocardial infarction, which can lead to disabling angina or congestive failure. The scarred area of infarcted myocardium balloons out to form an aneurysm — usually filled with clot that impairs myocardial function.

Utilizing cardiopulmonary bypass, the aneurysm can be excised. In a group of selected cases reported by Key et al[13] from the Toronto General Hospital, the operative mortality was about 10 percent with marked improvement at follow-up. This might be described as infarctectomy in the chronic form of coronary artery disease.

End Stage Myocardial Scarring

Most of the 74 heart transplant recipients so far reported suffered from disabling coronary atherosclerosis. These patients had reached the end stage of their disease and no treatment — medical or surgical — could improve their condition. The major problems include donor supply and rejection. Although transplantation remains a highly experimental procedure, its judicious, well-studied, continued application in the treatment of these patients with no other hope for any life at all appears justified.

The future

This short review points out the two major areas in which future research will be concentrated. In the management of acute coronary thrombosis, with its high mortality, a wider application of the infarctectomy operation should occur. The perfection of mechanical devices, both as supportive techniques and as artificial heart replacements, will be the real advance in the next 25 years.

In the severely disabling form, heart transplantation will continue. If the basic scientists can ultimately identify and prevent the rejection phenomenon, and if the donor supply can be improved, it might become a routine procedure. Our experience to date with prosthetic valve replacement leads us to speculate that a truly mechanical heart will ultimately be developed. Whatever the case, the advances of the next 25 years in cardiac surgery will be as exciting as those of the past 15 years.

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Nursing the patient after heart surgery

Rapid developments in cardiac surgery in the last 15 years have meant exciting changes in nursing. Today, words such as mechanical respirators, cardiac monitors, central venous pressure, tidal volumes, defibrillators and blood gases, are as common to the surgical nurse as the word "heparin" was to her counterpart 18 years ago.

Judith R. Wass

Each patient facing heart surgery approaches the event with fear, hope for the future, and expectations of the surgeon, the nurse, and the hospital. Often it is difficult for him to discuss his postoperative care, as he is afraid to acknowledge the risks that he knows are involved in heart surgery.

Naturally, previous surgery and hospital admissions influence the patient's attitude to the operation he faces. Even so, each patient goes to surgery with the knowledge that his heart is his link to life.

In the days preceding surgery, the patient meets a variety of people – physiotherapists, x-ray technicians, blood technicians, clerks. Somehow the nurse must interpret the roles of these health workers to the patient, and, at the same time, provide an atmosphere that allows him to express his fears, hopes, and expectations.

ICU nurse visits

Preoperative teaching is geared to the patient's understanding and acceptance of the operation. Usually the questions he asks indicate what further information he requires. Generally, however, he needs explanations about intravenous therapy, monitoring, chest drainage, oxygen therapy, deep breathing, and coughing.

Prior to surgery, the patient receives a visit from the nurse who will look after him postoperatively in the intensive care unit. This visit benefits both patient and nurse. The patient feels more secure in knowing the nurse who will be so important to him postoperatively, and the nurse is able to evaluate the patient's physical state before she receives him in her unit. Also, the visit allows her to identify her patient as a person – something that her preoccupation with technical skills in the ICU unit might otherwise inhibit.

The patient's family is not neglected during this preoperative period. Family members are told of the time of the patient's surgery, the visiting hours, and the number of visitors allowed. They are assured that the surgeon will talk to them shortly after the surgery, and that they may visit their relative within a few hours of the operation.

Circulatory assesment

Postoperatively, the nursing objective is to maintain the patient's circulatory, respiratory, and neurological status. Checking of the vital signs – blood pressure, apical rate, respiration, central venous pressure – is the first task. In our intensive care unit, we record blood pressure with the sphygmomanometer and apical rate with a stethoscope.

Direct observation of the patient's skin, lips, and nail-bed color is important. A nurse's ability to observe, perceive, and report the slightest change is invaluable if prompt treatment is to be given. An electronic monitor, which reports electro-

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encephalograms and arterial pressure, helps the nurse in her observations.

Obviously the nurse must have a fair amount of knowledge about the monitoring equipment. She has to learn about the basic arrythmias and be able to recognize their appearance on the oscilloscope. Premature ventricular beats, atrial flutter, atrial fibrillation, ventricular tachycardia, and bundle branch block are common in patients having valves replaced or a mitral valvotomy. Patients with pacemakers implanted have to be observed carefully for irregularity in pattern and the development of heart block. The sensitivity of arterial pressure monitoring assists the nurse with the critically ill patient in whom blood pressure readings are inaudible.

Fluid balance

Chest drainage is recorded frequently to determine the need for blood replacement. The nurse has to be aware of the acute problems of hemorrhage and cardiac tamponade, and should correlate the observations of vital signs and chest drainage.

Central venous pressure is an excellent indication of hypo – or hypervolemia. Measurement of central venous pressure is accomplished via a catheter that leads from a median cubital vein to the superior vena cava and right atrium. A rise in CVP is reported immediately since it generally indicates that the patient's circulatory system is being overloaded with excess fluid. Overloading increases the work of the heart, which may be unable to cope with this added stress.

Urinary output is decreased in the early postoperative period as the endocrine response to stress of surgical trauma, described by Selye, includes the increased production of an antidiuretic hormone, ADH. ADH controls water absorption in the tubules; it is a posterior pituitary hormone. Output is recorded to evaluate the functioning of the patient's renal system. An output of less than 20 cc. an hour is reported promptly. Specific gravity is measured every eight hours to determine if the concentration of the urine being produced is adequate. Decreased urinary output may be the result of hypovolemia, hypotension, or renal shutdown.



The vital signs are the first task after heart surgery. Modern equipment in intensive care wards helps the nurse record quickly, accurately, and efficiently.

Respiratory evaluation

Most patients having open heart surgery will return to the unit with an endotracheal tube in place. This is connected to a respirator, such as the Mark VII, Bird, or Engstrom. Secretions are suctioned frequently from the tube to maintain a clear airway and prevent aspiration into the lungs. Sputum and tracheobronchial aspiration specimens are sent to the laboratory routinely for culture.

Patients are encouraged to deep breathe and cough every hour, and maximal inflations are done with an Ambu bag to inflate the lower lobes of the lungs. The nurse measures tidal volumes every hour to determine the volume of air being expired with each breath. The anesthetists in our unit prefer to maintain a volume of over 300 cc. when a patient is on a respirator. Interpretation of this information in relation to respiratory rate and total amount of air expired in one minute is an important observation. The patient may be hyperventilating to obtain an adequate amount of air.

Blood samples are drawn from an indwelling arterial catheter at specific times for calculation of the arterial blood gases. This catheter is kept patent by flushing it with a heparinized saline solution. Measurement includes the pH, pO2 CO2, O2 saturation.

The nurse watches for any change in blood gas content that would indicate respiratory distress. Her observations include increased respiratory rate, restlessness, labored respirations, anxiety, and a change in level of consciousness. (For a complete discussion of blood gases and their significance, see "Blood Gases" by C. Betson, THE CANADIAN NURSE September 1968.)

Evaluation of neurological status

The patient admitted to the intensive

care unit following heart surgery is observed for response to verbal and physical stimuli. This neurological evaluation is important because of the possibility of cerebral embolism during open heart surgery. Air not completely evacuated from the left ventricle prior to closure may result in an air embolism. Also, calcium or fibrin can be dislodged from the calcified valve and cause an embolism. These observations are continued throughout the patient's stay in the unit.

It is necessary also to evaluate the patient's response to time, place, and person. Motor ability can be tested by asking him to grasp the nurse's hand and move each extremity independently. Sensory response of the extremities to touch and pain is another important observation.

Physical comfort of the patient is assessed frequently as pain will prevent him from coughing and deep breathing adequately and can also be a cause of hypotension. Analgesics are prescribed by the surgeon; the drug most commonly used in our unit is Pantapon Hydrochloride 2 mg. per cc. of solution, given intravenously as necessary.

The patient may respond adversely to narcotics if he is in shock, has renal impairment, or decreased pulmonary function. For this reason, the nurse is alert for any signs of toxicity caused by drug administration. At the same time, she knows that delay in administering analgesics will decrease their effectiveness.

Physical comfort can also be achieved by basic nursing measures. A daily bath is given to all patients as their body temperature is elevated postoperatively and they often perspire profusely. A flannelette sheet used as a drawsheet is less likely to cause skin irritation when a patient needs many changes of linen. Turning the patient frequently adds greatly to his comfort, particularly if a soothing back rub is given at the same time.

Emotional support

The underlying fear of all patients who have had cardiac surgery is the knowledge that death may be just a few heart beats away. Added to this fear is the strange bewildering experience of the intensive care unit environment at a time when he is least able to cope with this additional stress. The patient will naturally look to the nurse for support and understanding.

The unusual behavior seen in an intensive care unit may be attributed to both physical and psychological complications. Metabolic disturbances, drug reactions, and electrolyte imbalance may lead to disorientation, visual, or auditory hallucinations. For example, the first indication of respiratory failure may be confusion and restlessness.

The effect of the environment of the unit and the intensified nursing measures on patient behavior cannot be ignored. The activity in the intensive care unit is often at a high level, day and night. Chest routines, monitoring, and hourly observations of vital signs all are required on a 24-hour basis. A day-night routine is difficult to establish with the acutely ill patient and exhaustion soon leads to bizarre behavior.

Studies of an open heart recovery room by D.S. Kornfeld* have demonstrated that patients may experience anything from perceptual illusion to auditory and visual hallucinations. Disorientation to time and place has been noted in many patients.

Relatives also may be reassuring for the patient. A short visit with a loved one provides contact with his personal world. Often a cup of tea held by a wife is more willingly taken by the patient.

The nurse must remember the patient's need for privacy when attending to his care. Often, he is embarrassed by his complete helplessness and dislikes being exposed unnecessarily.

To summarize, the monotony and timelessness of the unit, the limitations placed on the patient's movements by monitoring equipment, and arterial and venous pressure lines all appear to contribute to the changes seen in patients during their stay in the unit. Therefore, the nurse has to recognize these psychological changes and be prepared to help the patient cope with them. Without respect for the dignity of the individual, the nurse becomes a technician – skilled, but unable to give her patient the "tender loving care" so necessary in this unit.

Simple measures help

What can a nurse do to provide comfort and relief from anxiety for the patient? Often the simplest measure is enough. Turning the pillow over, remembering to put a little ice in the drink, placing a pillow at his back while he is sitting at the side of the bed, giving a back rub that reaches the aching muscles. These basic nursing measures, combined with a warm smile and a soothing voice, do much to make the patient feel at ease.

With the era of cardiac transplants now here, nursing will be faced with new challenges for the refinement of specialized skills and techniques. The unique contribution of the nurse in the care of the heart patient must keep pace with the advances in surgery.

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A new category of health worker for Canada?

Carlotta L. Hacker, M.A.

Medically trained people, known as "physicians' assistants" or "medical assistants," have recently been employed in certain areas of the United States to relieve doctors of much of their routine work. At Duke University, North Carolina, a two-year course of training was initiated, which prepared, as physicians' assistants, people who had a medical background but who lacked the opportunity or academic qualifications to become doctors. The Duke trainees have mostly been medical corpsmen. Their duties have included such tasks as taking histories, drawing blood, collecting specimens for gastric analysis, doing basal metabolism rates, electrocardiography, and skin-testing for allergies. At Denver, Colorado, "nurse practitioners" have been trained to take on comprehensive well-child care and to identify and refer chronic conditions. Other institutions in the United States are following this lead. In Russia the feldshers have, for many years, been acting as doctors' assistants. In Europe trained midwives often serve similar functions.

Should Canada also train and employ such people? Is there a need for them here? If there is a need, would nurses suffer by the introduction of a new class of worker? Would it be better if nurses gave the necessary assistance to physicians?

THE CANADIAN NURSE *sent the author, a freelance writer and researcher, to interview some of our doctors and nurses who have expressed strong opinions on this controversial subject. Their views are given here.*

DR. J. B. R. MCKENDRY is convinced that there is a real need for physicians' assistants in Canada, first because of the demand for primary contact medical people, and second because a fairly high proportion of medical troubles are relatively easy to manage. He believes that with a situation of too many chiefs and not enough Indians, it is at present the chiefs who are spending much of their time doing simple repetitive tasks.

"It's a waste of physicians' training," says Dr. McKendry. "It's demeaning for them to be doing these tasks, and it's expensive for society to have them do them."

Dr. McKendry, who is Chief of the Department of Metabolism at the Ottawa Civic Hospital, feels that, in his own case, he could quickly train a person to be of enormous help to him in managing the large numbers of patients who have uncomplicated diabetes and in handling the straightforward routines.

"A doctor is limited now in what he can do in a day by the fact that he's only got two hands, two eyes, and 24 hours. But he could almost double his effectiveness if he had someone who would take off his hands the repetitious mix of work that inevitably is found with his more demanding cases. Then he would not only have the time, but also the energy, to deal effectively with these more demanding cases."

Dr. McKendry does not think that a nurse, as such, would fully answer these requirements. What he would like to see is the creation of a new category of worker who would work for the physician on a straightforward, employer-employee basis and be paid by the physician. And he would prefer this person to be called *practitioner-associate* rather than *physician's assistant.* "This might then be shortened to *practitioner,*" he says, "and then the doctors would properly retain their own title as doctors."

The fact that Dr. McKendry has views even on the name for these people is some indication of the thought he has given to this category of worker. He has already written a number of papers on the subject, he has studied the courses for physicians' assistants offered at Duke University and at Colorado, and he has visited Russia and observed the feldsher training facilities there. The result is a clear idea of how practitioner-associates could be introduced into Canada.

He suggests the following as a possible program.

The position of practitioner-associate would be open to nurses, to ex-servicemen with medical experience or to any other group with some medical knowledge, and to high school graduates. It would require a four-year course, al-

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Carlotta Hacker is an English and History graduate of St. Andrews University in Scotland. Her writings include articles and short stories for Pan Books, London's *Observer, The Cornhill Magazine*, and for the Blue Cross periodical *Blue Gold*. In 1965 she contributed an article to THE CANADIAN NURSE on the Canadian Medical Expedition to Easter Island. Her book, ... *And Christmas Day on Easter Island* has recently been published by Michael Joseph Ltd. of London, England.



Dr. J. B. R. McKendry: "Maybe the ambitious vanguard of nurses should be pulling off and going into a new cadre of professionals.

though previous work in medicine or nursing could count as credits and could shorten the course. The course itself should be sponsored by a university in affiliation with hospitals, clinics, and doctors' offices for practical training.

The first three years would concentrate on classroom and laboratory work and would be in an institute attached to a university. Dr. McKendry believes that many universities would be glad to form such institutes, particularly those universities that at present are unable to open full-scale medical schools because of financial and practical difficulties. The fourth year would be devoted entirely to clinical and specialized training in the appropriate field. For example, a practitioner-associate who was preparing to work under an obstetrician as a trained midwife would take his final year in a department of obstetrics.

Having successfully completed his course, the practitioner-associate would receive a diploma and a license permitting him to practice in the area in which he had trained, under the supervision of a doctor, and on a one-to-one basis with the doctor.

Dr. McKendry stresses the importance of this one-to-one basis. He does not intend that a doctor should employ more than one assistant, partly because a good working relationship is easier to establish with one person than with a group, and partly because supervision is easier. And supervision is essential as the physician would be morally and legally responsible for the actions of his assistant. An Act of Parliament would be necessary to stipulate the legal responsibilities of practitioner-associates and the physicians who employed them.

With regard to finance, Dr. McKendry suggests that the practitioner-associates should be subsidized during training, just as medical students are being subsidized at present.

"The country can afford this much more readily than it can afford to double the number of MDs," he says.

After training, the assistants would be paid by the doctors who decided to employ them. Renegotiation of contract every two years should be a basic principle. This, together with the good employer-employee relationship which is envisaged, would minimize possible agitation from a practitioner-associate's union, for it would enable a really competent practitioner to command a salary equivalent to the value of his work.

There should be no ceiling to this category: if an assistant were to prove he had the ability of a potential MD, then he should be permitted to enter medical school, counting his diploma as a credit toward his medical degree.

But how are nurses going to feel about all this? Well, by this scheme, they would also be given the chance of mobility, according to Dr. McKendry.

"And such nurses as might resent the creation of practitioner-associates are probably the very nurses who should try to qualify for the position," he suggests. "Maybe the ambitious vanguard of nurses should be pulling off and going into a new cadre of professionals. Then the other nurses could get back to nursing."

How will the patient feel? "By and large, I think that when a doctor, in whom a patient has trust, designates someone else as his replacement or assistant, then the patient accepts this, knowing that if he is very sick or if there is some great emergency, then the doctor is available and will be called."

What about computers and electronic aids? Mightn't we soon find that machines could replace assistants in much of their work?

"We are all equipped with computers in our heads that are vastly superior to any computer that can be envisaged in the next century," Dr. McKendry answered. "There may be a little help from electronic communications, but they, too, depend on what's fed into them."

On all counts, Dr. McKendry is convinced that a new category of worker is the solution to the problem of the overworked physician.

"Without something like the approach that I'm describing," he says, "we won't begin to meet the need for primary contact personnel in this country in this century."

"The primary contact person – the person who is to see the patient and decide what is wrong with him – should not be anything less than a doctor."

In this statement, DR. A. L. CHUTE is referring to normal conditions where a doctor is available – not to isolated parts of Canada. He does not think that in normal circumstances an assistant should be responsible for deciding which patients require the attention of an MD.

But it is not only in primary contact work that Dr. Chute opposes the idea of physician's assistants. He questions the need for them at all in Canada, mainly because he questions whether there really is a shortage of physicians here.

"And unless you predicate a shortage of physicians, there isn't any reason to say that there should be physicians' assistants," he argues.

With many years of experience as Chief of Pediatrics at Toronto's Hospital for Sick Children, with medical wartime service, with teaching experience at the University of Toronto as Professor of Pediatrics, and now as Dean of Medicine, Dr. Chute's interests range over a wide spectrum of medical subjects. His reaction to the present subject is to question whether perhaps medicine is suffering from a distribution problem rather than from an actual shortage of physicians.

"We provide training posts for people indiscriminately," he says. "We are training three or four times as many surgeons as we need. If we reduced the number of training posts for surgeons and made more training posts available for other people, then we might redirect our qualified manpower into more effective areas."

Similarly, Dr. Chute believes that if the position of the family doctor were made more attractive – for instance, by the formation of group practices, so that a general practitioner would know that a weekend off work really was a weekend



Dr. A. L. Chute: "I don't think there's any necessity for creating a new breed of cats."

off – then this, too, might direct doctors into more needed areas.

But even if there does prove to be a shortage of physicians, Dr. Chute does not like the idea of creating a new category of worker, because another category would splinter everything further. There would be new union problems and another group of people worrying about their rights and privileges, without the end purpose – patient care – being accomplished.

"No," he says. "I don't think there's any necessity for creating a new breed of cats."

Dr. Chute would far rather see a drawing together of the existing ranks of health workers, a drawing together into a team approach aimed toward the welfare of the patient. He believes that present gaps in medical care could be filled by a better use and a more appropriate training of the people already available. He points out that for years nurses have been performing much of the work that the medical assistants at Duke University list in their duties. Where necessary, they could take on more.

In other words, specialize the nurse. Break free from the thesis that "a nurse-is-a-nurse-is-a-nurse and they all get paid the same." Let nurses, who have the ability and the desire to do so, take a course of training for some particular job. But let them, like specialist doctors, receive recognition and financial rewards for their extra training. And, just as specialist doctors are still in fact doctors, let specialist nurses remain nurses. There's no reason to call them anything different.

"This is the real answer," says Dr. Chute. "Nursing has to be specialized, and then automatically you've got your doctor's assistant."

MLLE JULIENNE PROVOST and MLLE MARIETTE DESJARDINS see things otherwise: a nurse is a nurse, and she should in no way aspire to be a little doctor.

Sitting in their office at the University of Montreal, these two Assistant Professors of Nursing eagerly discussed the advantages and disadvantages of introducing doctors' assistants into Canada. They look neutrally on the suggestion, seeing the assistant as being neither superior nor inferior to the nurse: like the social worker, he or she would simply be something different. However they would not wish the physician's assistant to be recruited from the nursing staff, any more than they would wish a nurse to fill much the same function by becoming over-specialized.

Mlle Provost is particularly concerned about the *fonction indépendante* of the nurse: her true role in caring for the patient. If the nurse is to be entirely removed from this, either as a specialist nurse or as a physicians' assistant, then she would no longer be following her vocation. Even a clinical nurse should remember that she is primarily a nurse and should see that something of this role is retained.

But, as Mlle Desjardins pointed out, if there were more clinical or specialist nurses they probably could take over the assistant physician's functions while preserving their independent function, as shown in the Colorado University experiment. But, if the physician's assistant were recruited outside nursing, and if he were to take over some non-nursing work, then it could return nurses to nursing.

However, both instructors are aware of the possible problems: How will the clinical nurse feel about the creation of this new category of worker? Will she feel threatened by it? And who will be responsible for physicians' assistants who are working in a hospital – the doctor or the hospital administrator? Will assistants give orders to nurses and, if so, will nurses be obliged to obey the orders? They should be licensed, but they may be difficult to control if they are licensed. How will the public be protected?

Mlle Provost and Mlle Desjardins would like to see a survey conducted that would answer these questions and would evaluate the need for such assistants in Canada. One can learn a certain amount from the experiment in the United States, but physicians' assistants there, particularly at Duke University, are fulfilling specific needs, one of which is the employment of medically-trained ex-servicemen. So they suggest that an opinion poll should be taken among our own doctors, specialists, and clinical nurses; that a research project be started and that some experiments be made here to see how such assistants would fit the Canadian needs. For both Mlle Provost and Mlle Desjardins do feel that physicians' assistants might well serve a useful function within medicine in Canada, provided they are introduced carefully and with vigilance.

ALBERT WEDGERY does not share this view. Although he believes that there is a need for an assistant to the doctor, he is not by any means convinced that this means creating a new category of worker.

"It's all very well to say: 'we need an assistant so we'll set up a new category of worker,' but every time you create something new, you have to live with it."

Mr. Wedgery can foresee a host of problems that will have to be lived with if physicians' assistants are introduced into Canada. Inevitably there will be the formation of unions pressuring for higher



Mlle J. Provost: "Physicians' assistants might well serve a useful function within medicine in Canada."

Mlle M. Desjardins: "If the physicians' assistants were to take over some of the work presently being done by nurses, it could help to return nurses to nursing."



salaries and for a stronger position within medicine. There will be legal difficulties, particularly if, as in the United States, the assistants are not licensed. And then there is the matter of control: the assistants might be able to set up on their own, charging what fees they liked and functioning as they liked, unless they were registered with some organization that could control them.

"And I have a feeling," he says, "though I may be entirely wrong, that this whole medical assistant thing is a stop-gap, that it's abortive.

He suspects that it wouldn't be long before physicians' assistants wanted to go further in medicine, and the only future he can see for them is that they should be allowed to use their experience as credits toward entering medical school. In which case, unless a very large number of assistants were trained, we would be back at stage one, with doctors needing helpers.

As President of the Registered Nurses' Association of Ontario and as one who has considerable experience in nursing, Mr. Wedgery is naturally concerned about the effect the formation of this category would have on nurses. He fears that physicians' assistants could potentially separate the nurse from the doctor. He also fears that they might remove from the nurse's duties such procedures as starting intravenouses and taking blood pressures. While he is certainly not suggesting that nurses should take over medical practice, he would like the medical procedures that have been performed competently by nurses for a long time now to be recognized as nursing practice and placed in the nursing curriculum. For he feels strongly that whatever brings the nurse closer to the patient can become part of nursing.

"Otherwise," he says, "if the bulk of nursing is going to be done by nursing assistants and the medical procedures done by the physicians' assistants, then what are the nurses going to have left to do? We can easily find ourselves in danger of isolating ourselves – like painting ourselves into a corner."

Specialization will have to come. This Mr. Wedgery recognizes as inevitable. Even so, he would like to see a return to total patient care, and some move could be made toward this if it were nurses who were to give the necessary assistance to the physicians.

"It seems to me that, because of the background of nurses, because of their intimate daily and hourly contact with the patient, there is no reason why nurses – probably specially trained over and above the normal nurse's education – should not be doing these tasks."

"I think that there is a need for physicians' assistants in Canada and I think that, if the scheme is developed well, it may be a very good thing.



A. Wedgery: "Every time you create something new, you have to live with it."

MARGARET MCLEAN, Senior Nursing Consultant, Hospital Services Branch, Department of National Health and Welfare, settled back in her chair and stated her case clearly.

First, she distinguished between the type of medical assistants employed in Colorado and the type employed at Duke University. She considers the former to be similar to clinical specialists in pediatric nursing and sees no reason for such people to be placed outside nursing. But the situation at Duke University is different. The people there are not performing as nurses. They are assistants to the doctors and therefore they should be classed as such.

Miss McLean sees the physician's assistant as being just that: his assistant. Not someone who does a little bit of nursing and a little bit of laboratory work and so on, although he may bring some of the nurse's present jobs back into medical practice. "After all, is it nursing to draw blood from a vein? " Miss McLean asked. The assistant's main purpose will be to relieve the doctor of much of his routine work, including primary contact work. However, he must not be allowed to come between the doctor and the other health professionals, such as nurses, dietitians, and physiotherapists.

From the legal and practical points of view, Miss McLean feels that the doctor will have to take responsibility for the work of his assistant, and the assistant will have to be licensed. The alternative – that of licensed nurses being given further training in special subjects – would not produce the type of person that is required, for nurses have additional functions and additional loyalties. The result could be an uneasy compromise and yet another "grey area."

But of course nurses could train to become medical assistants, if they were prepared to leave nursing.

"Some nurses would like to be doctors and they might see this as a status thing," says Miss McLean. "But it wouldn't attract me! "

She does not foresee any great depletion in the nursing force by the creation of this new category, nor does she think that it should give rise to rivalries. "The nurse who likes caring for the patient is not the one who is going to become a medical assistant."

For the training of the physician's assistant, Margaret McLean inclines toward a two-year course, although it might have to be longer; this would have to be decided by the medical profession. She is conscious that the success of the experiment will depend very much on how it is handled and how controlled, and therefore she suggests that only a few medical assistants should be taken on initially. The curriculum could then be modified, where necessary, with the next group of trainees.

One thing she would like to see clearly defined at the outset is the role of the physician's assistant – just as she would like there to be a clear and mutual understanding of the roles and objectives of all other health workers. If this can be agreed harmoniously among doctors and nurses, and understood by the assistants themselves, then she feels that the introduction of these assistants into medical practice could be of great benefit to Canada.

"I don't believe that just because something is right for one country, it's automatically operationally right for another country," said DR. SHIRLEY GOOD firmly. "You have to look at the needs, you have to look at the distribution of population, and I question seriously whether we need another kind of health worker: one more person who will come between the physician and the patient and health care."

Looking at Duke University, for instance, Dr. Good, who is Consultant in Higher Education, Canadian Nurses' Association, can see an identified need for physicians' assistants there and she can see that there is a large number of medical corpsmen available to fill the need. But Canada does not have the same manpower problem as the United States, nor does Dr. Good feel that our physicians necessarily require similar assistance.

"I don't think we have a shortage of physicians or a shortage of nurses, but I do think there is a shortage of *nursing.*"

If nurses were to extend their abilities to give greater nursing care and if capable nurses were given more latitude to develop their skills, then nursing itself could be improved and the existing void between the work of doctors and nurses could be filled. So, although Shirley Good does not hold that we should copy the pediatric program at Colorado, she could view with equanimity something like that happening here, if it proved to be necessary, as the Colorado students are registered nurses taking further training for a specific purpose.

But, to create a whole new category of worker: No!

Why should we? asks Dr. Good. Have we proved that it is really necessary? If far more use were made of existing technical aids and more use made of the resources within the nursing profession, then we shouldn't require another worker.

In any case, who would license physicians' assistants? To whom would the licensure fees be paid? If, like other groups, they licensed themselves, would



M. McLean: "Some nurses would like to be doctors and they might see the physicians' assistant role as a status thing."

Dr. S. Good: "Just because something is right for one country, it's not automatically right for another."



they then demand to be a profession in their own right and begin to fight physicians? If, on the other hand, physicians licensed them, then presumably the physicians would be legally responsible for them. If this were so, or if the assistants were unlicensed, would the physician responsible lose *his* license if something happened to the patient? And where would these workers get their code of ethics?

Another point Shirley Good raised was: Who will pay physicians' assistants? It's all very well to say that doctors will provide the salaries, but will a doctor really be prepared to accept such a large drop in his own income? It could amount to $10,000 a year or more. If the government pays, then up goes the medical insurance.

There is the possibility, too, that we could be making work rather than reducing it, for someone will have to teach these people. Will it be doctors who do so?

Dr. Good was also concerned about the effect such a category of worker might have on the nursing profession. It could push nurses back both financially and psychologically so that they found themselves in the position of nurses' aides or nursing assistants.

She would far prefer to see nurses themselves being given the chance to branch outwards so that those who wished could take on more clinical and technical work.

"You see, the nurse, if specially trained, can bring with her into technical work the kindness and humanness that is her unique function. And a thoroughly educated person in a balanced educational center should be capable of bringing this sensitive approach to patient care in an age of technology." □

idea exchange

How Much Bleeding?

When a doctor is called to the telephone, whether it be day or night, and whether he be an intern, resident, family physician, or specialist, and he is told that a patient is "bleeding heavily," that information should have a specific meaning.

Often it is extremely difficult for a nurse to communicate to the doctor a reasonable conception of the amount of bleeding. Uncertainty on his part results in wasted visits to see patients who are not actually bleeding excessively, as well as the anxiety that ensues when he is unable to make these visits immediately.

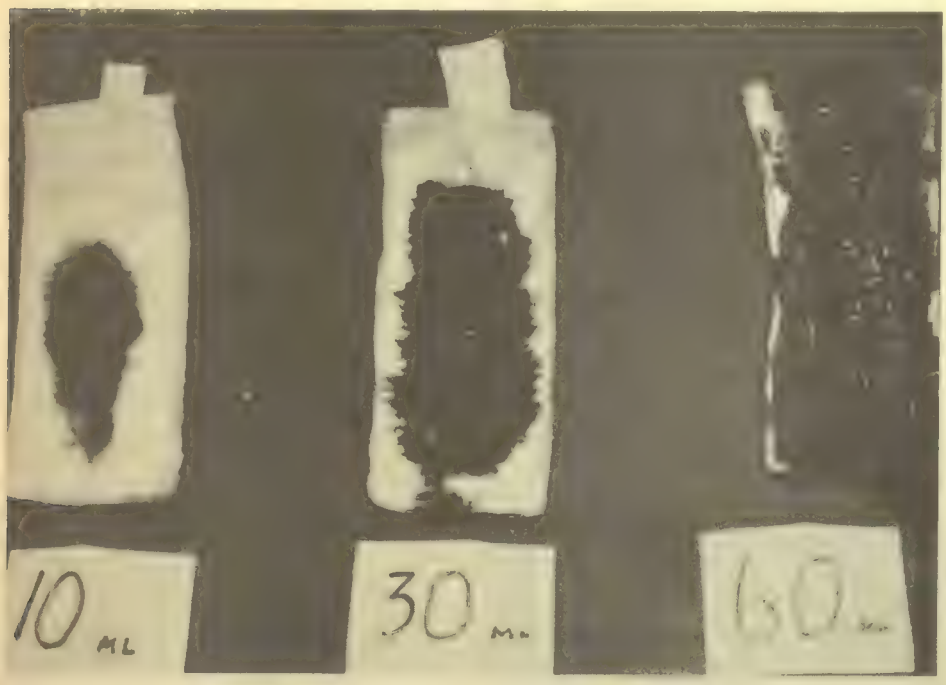
To avoid these difficulties, a system was developed 15 years ago that has been used in our hospital ever since.

Three perineal pads are prepared. Onto the first one, 10 cc. of blood is dropped from a syringe, 30 cc. onto the second, and 60 cc. onto the third. These three pads are then laid side by side with a card under each showing the amount of blood, and a color photograph is taken. This picture is enlarged to eight inches by ten inches and used in the nursing school and on each female ward as a ready reference.

Since this system has been used, the nurse has been able to report with reasonable accuracy that "the amount of blood is about 50 cc. per hour" or "the blood amounts to 10 cc. on a pad that has been in place for two hours."

This system can be put into use in any hospital prepared to spend a few dollars for photographs and will eliminate a great deal of aggravation and unnecessary effort.

Incidentally, the word "saturated" should be avoided, or used only to indicate that the pad drips from one end when help up by the other. — Michael Bruser, M.D., F.A.C.O.G., Misericordia General Hospital, Winnipeg.



Keep The Private Duty Directories Running

Recently we learned that members of some Private Duty Registries or Directories have encountered a problem similar to that faced by our members in 1966, and we thought that information about the way we solved our problem might be helpful.

In November, 1965, the Registered Nurses' Association of British Columbia notified the Victoria Private Duty Registry that RNABC could no longer provide financial support for the Registry after March 1, 1966. Immediately, the private duty nurses appointed a committee to explore ways and means of replacing the former registry to continue to provide a central service for private duty calls from the public, physicians, and hospitals.

A questionnaire was sent to many Private Duty Registries across Canada through the provincial registered nurses' associations to learn how they functioned. Many replies were received and the information thus obtained was carefully studied.

After careful consideration the private duty nurses decided to establish an unincorporated association — The Victoria Private Duty Registered (B. C.) Nurses' Directory.

Bylaws were drawn up and presented to the members. Receipt books were prepared, and officially adopted for use by directory members only. Arrangements were made with a local telephone answering service for 24-hour answering service coverage, including week-ends and statutory holidays. A Kardex system was prepared for the answering service office, listing names of available nurses, phone numbers, and preferred hours and type of work.

In February 1966, cards were sent to doctors, major hospitals, and also private hospitals. Lists of current members of the Victoria Duty Registered (B.C.) Nurses' Directory were sent to departments of nursing service of the major hospitals.

We also notified the press, and received good publicity about the new Directory.

March 1, 1966, the "change-over" proceeded smoothly. The Directory has functioned satisfactorily for almost

three years now.

The Executive Committee, which assumes responsibility for the Directory is appointed by the membership and consists of a president, a vice-president, treasurer, recording secretary, and registrar. Salaried staff is not employed nor an office maintained (other than the telephone answering service office). The registrar maintains the Kardex for the telephone answering service and the lists for the hospital nursing service departments.

Services of the executive members are on a voluntary basis, but the registrar receives a small honorarium to reimburse her for expenses incurred during the year.

Nurses who wish to join the Directory must be current members of the RNABC and also complete a comprehensive application form. The fee for registration with the Directory is $20 a year or a semi-annual fee of $10. Each member must obtain a copy of the official bylaws and agree to abide by them. Official receipt books are supplied; there is a small charge for these booklets.

Fees to the patient are presently $20 for an eight-hour shift, however these fees will be reviewed when so indicated.

Rapidly changing trends in nursing make it necessary for private duty nurses to keep abreast of changes. The Directory's regular monthly meetings help in this way, and arrangements have been made for the members to attend inservice classes and lectures at the major hospitals. Refresher courses at the University of Victoria and the University of B.C. are also available for our members.

The Directory has been working satisfactorily, is in sound financial condition, and the telephone answering service provides the private duty nurses with an interested and efficient service. We find that our cooperative effort has worked. Other Directories who would like more information should write to the President, Mrs. M. Fitzgerald, 966 Hampshire Rd., Victoria, B.C. — Janie E. Jamieson, R.N., Registrar, Victoria Private Duty Nurses' Directory.

A New Desing For Stryker Turning Frame Covers

A study of the nursing care of patients on the Stryker Turning Frame showed the need to design special covers. The aim was to make the patient more comfortable and facilitate nursing care.

The covers described in this article are the result of many months of work and experimentation. They have been in use for a trial period and have the following advantages over those used previously.

- The comfort of the patient is increased and it is easier to give nursing care.
- The covers are all one size and can be adjusted to fit the different-sized frames.
- Covers can be applied quickly and easily.
- Covers are securely fastened and remain smooth and taut.

The material used for making the covers is preshrunk flannelette, double thickness. The border on either side is bleached duck, which provides a firm edge and prevents tearing. The covers are applied over the canvas already on the frame.

Awning cord is laced through metal gromets spaced at regular intervals in the border. The lacing holds the covers so that the upper surface is smooth and taut. The size of the cover can be adjusted to fit the frame by folding it under at the head and/or foot. Several rows of stitching inside the border prevent the flannelette from tearing when the stabilizers are being put into place. Valcro closures are used on the covers for the forehead, arm, and foot supports.

The cover was such a success that we submitted the design to a local company. It has taken a copyright on the product and will be selling sets of covers (see "New Products," page 22). — Jessie F. Young, Supervisor, Neurosurgical Nursing, Toronto General Hospital, Toronto. □



research abstracts

Peterson, Alva L. *A study to determine – is the nurse in a double-bind when caring for patients on isolation care?* Montreal, 1968. Thesis (M.Sc.N.(A)). McGill.

The study is concerned with the nurse's approach to caring for patients on isolation care in single rooms on a medical or surgical nursing unit. To test the hypothesis that a nurse in this situation is in a double-bind, a comparison has been made of her approach to caring for patients under two situations: isolation and protective care. Both of these situations require the performance and maintenance of barrier nursing techniques – nursing measures necessary to prevent the transmission of pathogenic organisms.

The sample consisted of 61 third-year student nurses at a large general hospital school of nursing. A questionnaire of 35 statements directed toward each situation, isolation and protective care, was used to determine the nurse's assessment of her approach and the feelings of the patient in both instances. The difference between the means of the scores for isolation and protective care was statistically significant at the .001 level. The findings supported the hypothesis.

Lane, Marlene A. *The relationship between the physical adjustment of children to diabetes and the marital integration of their parents.* Montreal, 1968. Thesis (M.Sc.N.(A)). McGill.

This study is concerned with the relationship between family interaction and an ill member's adjustment to his disease. The hypothesis states that there is a positive correlation between the adjustment of a child to his diabetes and his parents' marital integration.

Twenty-two families were selected from the clinic and private files of a large children's hospital; the families met certain criteria including the child's age and family composition. Twenty families agreed to participate.

Marital integration is defined as agreement on family goals and lack of role tension between the couple. This was measured by Farber's Index of Marital Integration, administered to parents in their home. Child's adjustment to his disease is defined as a lack of physical symptoms of poor control and was measured by a six-category scale specifically constructed for the study. The six categories provide for deviation from normal in areas of hospitalization, illness, reactions, urine tests, blood sugars, and growth. The data were collected from records in the home and in the hospital.

Spearman's rho was used to measure the correlation between ranking of parents and children.

Gross analysis of the ranking of marital integration and child's adjustment does not indicate a relationship. More specific analysis shows a positive relationship between the child's physical adjustment and the lack of tension in his parents. This relationship is significant at the level of p. - less than .005.

Quittenton, R. C. *Community Colleges and Nursing Education in Ontario.* Windsor, 1968.

This report was prepared with the close collaboration of members of the nursing profession and hospital administrators in the area. It explores the need for a regional school of nursing in Windsor. The author recommended not to establish a regional school, but to augment the existing hospital nursing schools with the addition of a diploma nursing school, administered by St. Clair College and functioning as the core of a broad health science education unit. This nursing school would operate on a two-year program, with mature students constituting at least half the enrollment. The report contains comprehensive supporting data for this overall recommendation.

Studies are made of post-secondary enrollments in Ontario with forecasts predicting increased student competition for the hospital nursing schools. It is shown that bedside clinical training time available in Windsor could support a total student enrollment 50 percent above the current level, and Ontario nursing enrollments could double without any increase in hospital beds. It points out that student recruitment is not limited by availability of potential students, student financing, hospital school places, clinical training time, or demand for graduates, but rather by admission practices, training environment, and conditions of employment.

Population and hospital patient-day projections, coupled with a declining output of physicians in Ontario (based on a ten-year average proven performance – a percentage drop three times that of the diploma nurse output), indicate that by 1975 an output of 250 diploma nurses per million patient days, or a total output of 4,650 diploma nurses, would be required to maintain the overall 1955 level of Ontario health services. Comparisons made between Windsor and the rest of the province reveal that Windsor's output of total nursing personnel is about 25 percent better than the provincial average and the local hospital schools should therefore be encouraged to continue their outstanding performance rather than become incorporated into one regional school. Despite this superior performance, the expected growth of these hospital schools is inadequate to meet the forecast needs. For this reason a diploma program in the community college is recommended.

Wilson, Hazel. *A study to explore the relationship between absence events and the scheduling of time and work assignments of registered nurses and nursing assistants in selected units of a general hospital.* Montreal, 1968. Thesis (M.Sc.N.(A)). McGill.

This study explored the hypothesis that a relationship exists between absence events of nursing personnel and unsatisfactory situations relating to the scheduling of time and work assignments.

An absence event was defined as any absence from work for one or two days duration when the individual was scheduled to work.

The subjects were 177 registered nurses and 63 nursing assistants on 23 nursing units of a large general hospital. The number of absence events of all nursing personnel who had worked on each nursing unit during the six-month period, September 1, 1967 to February 29, 1968, was obtained from the personnel cards. There was a total of 982 absence events per 433 nursing positions.

A mean absence events score was computed for each nursing unit. Analysis of variance indicated that units above and below the mean differed significantly.

By means of a rating-type scale questionnaire, nursing personnel were asked to indicate the frequency of occurrences and extent of satisfaction with 10 statements each relating to the scheduling of time and to the scheduling of work assignments. A favorableness of occurrence score was obtained for the items of time, for the items of work, and for time and work combined. Nursing units were assigned to groups above and below the mean of the favorableness of occurrence scores, and an analysis of variance was employed to assess the difference of the groups on mean absence events scores.

research abstracts

The hypothesis was upheld for the scheduling of time but not for the scheduling of work assignments.

Rheault, M. Claire, *s.g. A comparison of students' achievement on a sequential learning experience with other measures of student progress.* Montreal, 1968. Thesis (M.Sc.N.(A)). McGill.

The major purpose of this study was to throw more light upon the all-time problem of evaluating student nurses who are learning to nurse. Present systems of evaluation in nursing education tend to appraise personality traits rather than students' progress. It follows that complex behaviors pertaining to students' and evaluators' attitudes, opinions, and habits shadow more or less an objective evaluation, and consequently the improvement or change in the student nurses' performance.

Assuming Gestalt writers' theory: "What happens to a part happens to the whole," a sequential learning experience called "daily plans for patient care" and performed by beginning students during the first term of study, was analyzed using a content analysis technique. The results were compared with other measures of progress used by the nursing teachers for the same students at their nursing school. The object was to demonstrate that students could be evaluated by assessing their progress on the DPPC.

The hypothesis stating "Students' performance on the daily plans for patient care is a reflection of her overall behavior in the school" had to be rejected, but the theory holds firmly for some of the individual measures of progress used by the school. Nevertheless, it is impossible that the method of assigning marks on the daily plans for patient care, in this study, may have influenced the result.

MacKenzie, Florence I. *A study of the relationship between the information about the patient as a person which is recorded on the nursing care plan and the information about the same person as recorded by the student after nursing the patient.* Montreal, 1968. Thesis (M.Sc.N.(A)). McGill.

This study is concerned with the problem of whether students tend to conform to the pattern of nursing care that they see practiced in the setting where they are learning to nurse. The hypothesis tested was that there is a relationship between the type and amount of information about the patient as a person as recorded on the nursing care plan and the type and amount of information recorded by the nursing student about the same patient.

A content analysis of the written nursing care plans for 10 nursing units in one hospital revealed that the information about the person could be placed in three categories: social-cultural, medical history and continuity of care, and emotional supportive. A form was designed on which this type of information could be recorded. Fifty-eight first-year students from 10 hospital nursing units in one hospital participated in the study. Data were collected from the nursing care plans of 104 patients assigned to these students. After caring for the patients during one day, the students recorded information about the same 104 patients. The amount of information written by the student was then compared with the amount of information from the nursing care plans.

The data were analyzed first by computing correlation coefficients for each category of information and for the total amount of information. A positive relationship at the .01 level of significance was found. In the 10 nursing units the information from the students was ranked on the basis of the mean scores, and Spearman rho correlation coefficients were calculated. A positive significant relationship was found in all categories with the exception of the social-cultural category.

These findings tend to support the hypothesis as stated. □

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Individuality in Pain and Suffering by Asenath Petrie, B.Sc., Ph.D. 153 pages. Chicago, The University of Chicago Press, 1967. Canadian agent: University of Toronto Press, Toronto.

Reviewed by Myrtle A. Kutschke, Assistant Professor, School of Nursing, McMaster University, Hamilton, Ont.

In this book, the author includes her own previously published work, that of others, and her current research.

The writing style is clear. The research method is described briefly in the text and in detail in the appendices. Although a rudimentary knowledge of statistics would allow the reader to understand the detail of the findings, clear interpretations are included.

In respect to research method, variables seem to be controlled statisfactorily. However the reader may have some quarrel with the small numbers in several samples. Also, "normal" subjects tend to represent groups readily available, such as student nurses. Some work was done to ensure that student nurses were not a bias sample. Random sampling is not evident.

Her research concerns individual variation in pain tolerance and sensory deprivation. "The results of the study . . . suggest a neurological or physiological basis for this variation. . . ." Using a simple kinesthetic test, individuals are placed in one of three categories in relation to their reception of stimuli. The three categories are augmenter, reducer, and moderate. As the words indicate, the augmenter tends to enlarge stimuli received, the reducer tends to decrease stimuli, and the moderate leaves the stimuli unchanged.

Findings indicate that patients tolerating pain poorly are augmenters, while those tolerating pain well are reducers. The reverse is true for sensory lack or isolation. The author explains that the augmenter perceives pain more fully and therefore has more sensation to tolerate. The reducer on the other hand has minimal sensation to endure. Because the reducer makes poor use of sensation, however, he feels the discomfort of isolation or sensory deprivation more intensely than does the augmenter.

Juvenile delinquents, alcoholics, and schizophrenics were among the groups tested. Each group showed a characteristic pattern. For example, there is a higher percentage of reducers among juvenile delinquents than among the control group. The author suggests that some of the destructive behavior of juvenile delinquents may be methods of increasing stimuli to overcome feelings of sensory deprivation. She states that these findings may be useful in planning programs of rehabilitation and prevention.

The effect of drugs on the relief of pain differs between the augmenter and the reducer. These findings are important to the nurse in anticipating results of administration of analgesics. If persons do vary neurologically or physiologically in their tolerance of pain and sensory lack, this data must be included in the problem-solving process of planning individualized nursing care. For example, an augmenter in a busy intensive care unit may find the bombardment of stimuli intolerable, while a reducer in a single room may find the relative lack of stimuli stressful.

This book is a good basis for clinical nursing studies.

Nurse researchers could design experimental studies to develop nursing interventions that would compensate for a patient's tendency to augment or reduce.

Communication for Nurses, 3rd ed., by Florence K. Lockerby, A.B., M.A. 120 pages. St. Louis, Mosby, 1968.

The third edition of this book proposes to tell the nurse how to communicate with her patients, her fellow workers, and the general public. Unfortunately, it has some difficulty in communicating with its readers.

Unlike the previous two editions, this one is directed not at student nurses but at nurses in general. With this more mature and knowledgeable audience in mind, the author is less chatty and uses more impersonal constructions and jargon.

The content as well as the style has been changed. Whereas half of the second edition is devoted to an explanation of communication in everyday life, only the first 27 pages of the third edition discuss communication in general. The rest of the book concerns communication for nurses.

Two changes in this edition could be considered improvements. This edition is more meticulously organized. Each chapter begins with a numbered outline of the chapter's contents and ends with a series of detailed questions on how to apply information contained in the chapter. More real-life examples in the form of anecdotal accounts of clinical experiences are used.

However, the author has become immersed in the complexities of language and rarely surfaces to enlighten the reader. For example: "In such situations, the following factors confound the participants' symbolization and mutual perception:

1. Peripheral involvement of other people
2. Emotional symbolization of incident
3. Disruptive lapse of time."

Such factors confound the reader as well.

The final chapter of the third edition is substantially the same as the final two chapters of the second edition. This section is specifically directed to the student nurse. It contains useful examples of how the student can establish rapport with her patients and help to create a favorable image for her hospital. It explains the value of active participation in nursing organizations, conferences, and workshops. How to deliver a public speech is outlined and notes on how to write for publication are given.

For the person interested in developing his writing ability, the annotated bibliography alone — which has been enlarged in this edition — makes this book worthwhile. Most of the books listed are directed primarily at writers.

Workbook For Community Health Nursing Practice compiled by Community Health Nursing Faculty, University of Washington School of Nursing. Palo Alto, California, Pacific Books, 1968.

Reviewed by Phyllis E. Jones, Assistant Professor, University of Toronto.

This book contains the material required during the community nursing experience of students in the school of nursing at the University of Washington. It is intended "to guide the student in the application of community health nursing prniciples and skills as a family and community health worker in the home, clinic, school and community."

It is a student workbook, designed to fit a three-ring binder and composed of removable perforated pages. The contents include a variety of guides: for observation of home visit, community analysis, family analysis, process recording, and self-evaluation. A listing of assignments required of students during this practice period is included. Statement of policies regarding student work should be helpful to students and agencies alike; these relate to such things as time in the agency, health, uniform, and transportation.

This book will be of greatest use in the educational setting for which it was design-

books

ed. The statements of philosophy and objectives are brief and how to use the book is not explained. Therefore, this book could not be transferred without modification to other settings. It does, however, serve as an example of an attractive and effective method of organizing aids to learning developed for a specific setting. It will particularly interest educators who deal with similar questions of organizing teaching aids.

Simplified Nursing, 8th ed. by Claire P. Hoffman, R.N., M.A., Gladys B. Lipkin, R.N., B.S., Ella M. Thompson, R.N., B.S. 692 pages. Toronto, J.B. Lippincott, 1968.
Reviewed by Leota Daniels, Instructor, Payzant Memorial Hospital, Windsor.

This text presents a comprehensive view of the fundamentals of nursing. A realistic approach to the human side of nursing is stressed. Although procedures are simplified, the principles of good nursing care are adeptly presented.

The first unit describes the community involvement required of the modern nurse. The importance of personality, interpersonal relations, spiritual factors, and legal aspects of nursing care to both practical and professional nurses is stressed.

The second unit acquaints the student with her role in relation to the family as well as the patient. Unit 3 deals with the functions of the human body. Colored diagrams are labelled in simple terms bringing the information to the level of every student. Glandular and organic function and body structures are well outlined.

The simplified approach to nursing is applied in succeeding units to topics such as nutrition, special diets, rehabilitation, nursing arts. Many of the more involved medical procedures such as hemodialysis, the cardiac pacemaker, and fetal monitoring are outlined in principle to help the student understand these involved medical techniques.

Unit six deals with the therapeutic approach to various disorders and abnormalities such as orthopedic, psychiatric, and cardiovascular diseases. A patient-centered approach involving individual needs is stressed.

The concluding unit concerns maternal and child care. The appendix includes a brief but comprehensive classification of therapeutic agents. Guidelines are given to the skilled observation of the effects of many widely used medications. A glossary of medical terms is also included.

This text is a comprehensive approach to nursing fundamentals. It can be easily understood by the student of practical nursing. This edition will also be helpful to the inactive nurse who wishes to return to the profession.

Adolescent Psychiatry, edited by S.J. Shamsie, M.D. 84 pages. Pointe Claire, Que., Schering Corporation Limited, 1968.

This book contains the complete proceedings of the first conference on adolescent psychiatry held in Canada at the Douglas Hospital, Montreal, in June 1967.

Commenting on the publication, the editor, Dr. Shamsie said: "In this one volume we have attempted to trace the development and treatment of adolescent problems, with particular emphasis on Canadian experience."

Subjects covered include: "The Varieties of Adolescents' Behavioral Problems and Family Dynamics" by Dr. R.L. Jenkins, professor of child psychiatry at the University of Iowa, and "Biological Growth during Adolescence" by Dr. J. Robertson Unwin, director of adolescent services at the Allan Memorial Institute in Montreal.

Dr. Henry Kravitz, psychiatrist in chief at the Montreal Jewish Hospital discusses the "Management of Adolescents in the General Hospital Setting." Dr. Jean L. LaPointe, superintendent of the Mont Providence Hospital writes about "Educational Problems in Disturbed Adolescents."

The "Adolescent in the Family," the "Adolescent in Juvenile Court," and "Adolescence as Rebirth" are covered respectively by Dr. Ronald B. Feldman, director of family and child psychiatry at the Jewish General Hospital, Dr. S.J. Shamsie, chief of adolescent services at Douglas Hospital, and assistant professor of psychiatry at McGill University, and Dr. Vivian Rakoff, director of psychiatry research at the Jewish General.

Clinical Nursing Workbook for Practical Nurses, 3rd ed., by Marilyn Gottehrer Freedman, M.A., R.N., and Justine Hannan, M.A., R.N. 207 pages. Philadelphia, F.A. Davis, 1968. Canadian agent: Ryerson, Toronto.
Reviewed by Donna Dineen, Charge Nurse. Auxiliary Staff, St. Mary's General Hospital, Kitchener, Ont.

This manual is an up-to-date workbook for the education of the student practical nurse.

It is divided into three sections. The first unit on medical and surgical nursing reviews body structure and function, and common systemic disorders, including the nursing care and pertinent drugs used in the treatment of these common medical-surgical conditions.

The second section, maternal and child health, deals with the pre and postpartum patient, nursing care of the newborn, and care of the sick child. Its major objectives are to protect the health of the mother and child and to lower the mortality rate. It points out how the practical nurse can best help her patients to attain these goals through her knowledge, skills, and attitudes.

The third section concerns the care of the mentally ill. It covers psychopathology, psychosis, and personality disorders with their appropriate nursing care, including shock and chemotherapy.

This book covers the entire practical nurses' course well. Its presentation is concise and complete. Although the psychiatry chapter and medications cover more than is actually necessary for the nine-month course, it proves to be interesting additional learning. The bibliographies are extensive, and therefore useful for extra assignments. Each new topic is preceded by an anatomical diagram; however, at times they appear jumbled and are too small to clarify needed details.

This manual would be of much assistance to the instruction of practical nurses.

ANA Regional Clinical Conferences, American Nurses' Association, 1967. Philadelphia/Kansas City. 322 pages. New York, Appleton-Century-Crofts, 1968.
Reviewed by Frances Pishker, Lecturer, School of Nursing, Queen's University, Kingston, Ont.

This book is a compilation of papers presented at American Nurses' Association Regional Clinical Conferences in 1967.

Fourteen papers presented at general sessions are concerned with three major issues: the nurse's involvement in health planning from national to local levels in the health care system in the United States; the use of computers in hospital; and discovery, dissemination, and utilization of the expanding body of nursing knowledge. Thirty papers presented at clinical sessions are evenly divided among the following areas of nursing practice: community health, geriatrics, maternal and child health, medical-surgical, and mental health and psychiatric nursing. Two papers presented at general clinical sessions are concerned with new methods of continuing education for graduate nurses: teaching new, highly specialized care techniques, and the use of communications media in inservice education programs.

The clinical sessions are particularly interesting. Nurse clinicians, teachers, and researchers discuss new approaches to nursing care in papers based on experimental studies, pilot projects, and case presentations. Some papers are primarily considerations of theory, and a few are refreshingly controversial. The section on geriatric nursing is well worth special attention for the dynamic and vital approach it brings to health care problems of aged people. Nancy Ilio's discussion of health care in an urban ghetto is a high point in the community health nursing section. The psychiatric and mental health nursing sessions include a number of exceptional papers.

The papers are six to eight pages in length, clearly presented, and easily read. Advantages of brevity are occasionally out-weighed by superficial treatment, but this may be a carping criticism in view of the overall merits of the publication. One can hardly expect such a large number of papers to be of uniform quality.

This volume has a lot to offer nurses engaged in direct patient care. It should be a

useful addition to nursing libraries and to the personal collections of nurses who either do not have access to a variety of periodicals or cannot find time to read them. Good references are provided with each paper, and the nursing teacher and student will find this book profitable when used in conjunction with source material.

How to Pass Entrance Examinations for Registered and Graduate Nursing Schools compiled by editors of Cowles Education Corp. 399 pages. Toronto, W.B. Saunders, 1968.

Reviewed by Dr. M. Josephine Flaherty, Lecturer, Department of Adult Education, The Ontario Institute for Studies in Education, Toronto.

This book is written for nursing school candidates. It purports to prepare such candidates for all the variations of academic and nursing tests used in current nursing entrance examinations. The latter include pre-entrance tests (for candidates seeking admission to basic nursing programs), which are thought to measure a candidate's aptitude for nursing as well as his general scholastic aptitude, and nursing achievement tests, which are written by graduate nurses seeking admission to university schools of nursing.

The book provides general information and advice about applying for admission to nursing school examinations in the United States, and instructions regarding how to take and score sample tests in the book. Sample tests include verbal, numerical, mathematical, reading comprehension, science, general information, and social studies tests for prenursing candidates, and medical-surgical nursing, maternal and child nursing, psychiatric nursing, and science in nursing tests for the graduate nurse students. With each group of tests, a short note on the nature of the tests and a set of "do's and don'ts" for dealing with the tests are given.

Without a set of well-defined objectives, it is impossible to evaluate the validity of any test or group of tests; hence no attempt has been made to do so in this review. It is probably more appropriate to look at the purpose for which the book was written and to attempt to assess its usefulness on the Canadian nursing scene.

If the purpose of an aptitude test is to help to estimate the future success of an individual in a particular occupation or educational program, it seems reasonable to sample certain psychological characteristics and acquired skills that are believed to be requisite to success in the specified occupation or educational program. Such measurement should be uncontaminated by specific preparation or practice by the candidate for the aptitude test itself.

This "how to pass" text is intended to give students some practice in test-taking; this in itself is probably not a bad idea, as it may help to dispel students' fears about the format and conduct of the test situation. However, the book also suggests that candidates study the correct answers carefully, score themselves, determine their area of weakness, and "plan a program of intensive study to insure success on the professional nursing school admission tests." This sort of procedure appears to lose sight of aptitude measurement, and to emphasize the content of the pre-entrance examination. Surely the aim of the schools should be to select candidates who really possess the characteristics and skills considered necessary for success in nursing rather than those candidates who are able to find out what is likely to be on the aptitude examination and learn the correct responses, without necessarily understanding why those responses are correct.

Similarly, with graduate nurse examinations, the objective is to assess the abilities and skills required by a candidate during her basic educational program in nursing and during her work experience in the profession. Attempts to practice or prepare specifically for the tests would tend to defeat the purpose of the examination program. Hence, one should question whether a "how to pass" book such as this one has any merit.

Although the sections on "do's and don'ts" of test-taking might be helpful to students who are unaccustomed to writing objective ex-



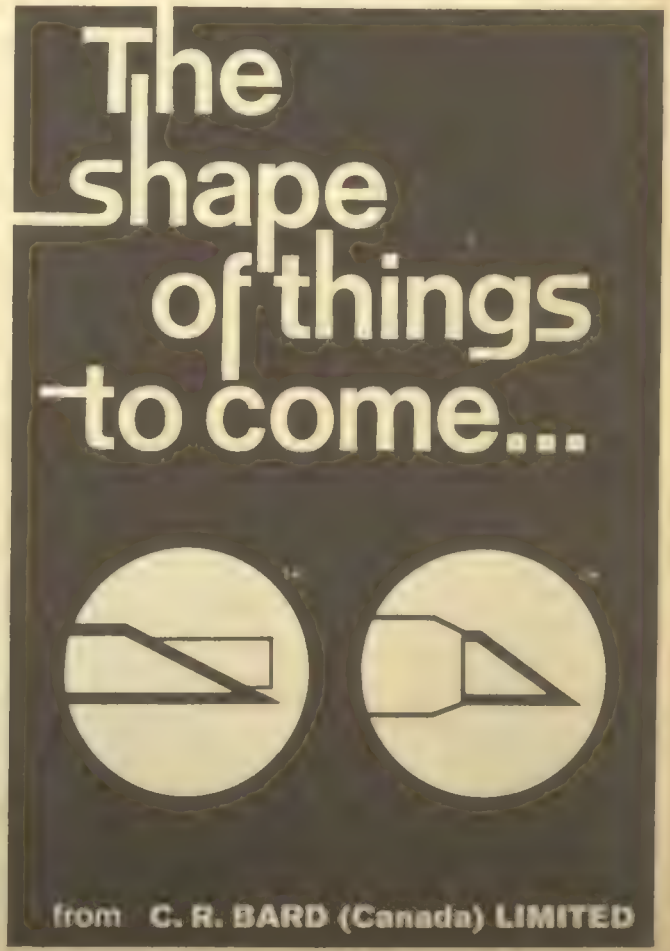
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aminations, the purpose and hence the content of the rest of the book seem to have little to recommend it for use by nursing school candidates. This book is not recommended for inclusion in nursing school libraries.

Biology of Human Behavior by Eleanor Page Bowen, R.N., Ed.M. 607 pages. New York, Appleton-Century-Crofts, 1968.
Reviewed by Margaret N. Lee, Associate Professor, School of Nursing, Laurentian University, Sudbury, Ontario.

In her preface to *Biology of Human Behavior* the author points out that the book is designed as a textbook for schools of nursing that offer one integrated science course.

The contents are divided into units and subdivided into chapters. These describe the anatomical and physiological functioning of the various systems of the human body and discuss the consequences of impairment to these systems. Each chapter ends with a discussion of the nursing implications of the contents of the chapter.

The illustrations are in black and white, although colored illustrations would probably have been more useful for students.

This book is written at a level that may make it useful to beginning students whose background of high school science is limited, and who have chosen to follow a nursing curriculum that includes only one integrated science course. It would be less useful to students in a baccalaureate degree program in nursing.

A Programmed Introduction to Microbiology by Stewart M. Brooks, M.S. 100 pages. Saint Louis, Mosby, 1968.
Reviewed by H. Kernen, M.A., R.T., Director, Medical Laboratory Technology Program, Saskatchewan Institute of Applied Arts & Sciences, Saskatoon.

Programmed texts are often most useful when integrated with a standard text used as a basis for a course of lectures. This text seems particularly well integrated with *Textbook of Microbiology* by Kenneth L. Burdon and R. P. Williams, 6th edition.

This book is divided into three parts: Fundamentals of Microbiology, Practical Aspects of Microbiology, and Microorganisms and Disease.

There are 21 diagrams. The program is linear, the template easy to operate, and it is less tedious than many linear programs.

Not all students like or profit from programmed texts and certainly not all students approach programmed texts in the same state of mind or use them in the same manner. To my surprise a group of nursing students in the Saskatchewan Institute of Applied Arts and Sciences, who were having difficulties earlier this year in learning microbiology, used this text in a novel manner with good results: they studied together as a group looking at one book and discussing aloud the possible answers to each frame.

Resuscitation : A Programmed Course by Leonard P. Caccamo, M.D., Edward Kessler, M.D. and J. Leonard Azneer, Ph.D. 113 pages. Toronto, The Ryerson Press, 1968.
Reviewed by Jean-Paul Dechêne, M.D., Chief, Anesthesia-Resuscitation Department, Laval Hospital, Quebec City.

This book, presented in the form of a questionnaire, reviews each phase of cardio-pulmonary resuscitation, thus enabling the reader to evaluate his knowledge.

Each principle is very well explained and completed by illustrations.

Blank space has been left for personal observations.

This book should be used as a basic textbook as well as a reference book by all paramedical personnel involved in cardio-pulmonary resuscitation.

The Lung And Its Disorders In The Newborn Infant, 2d ed., by Mary Ellen Avery, A.B., M.D., 285 pages. Toronto, W.B. Saunders, 1968.
Reviewed by Shirley E. Pitt, R.N., P.H.N., Nursing Coordinator, Home Care Department, The Children's Hospital of Winnipeg, Winnipeg.

This second edition, written primarily for medical clinicians and investigators, is an excellent reference book for all professional personnel who are working with the newborn infant. It is especially valuable for nurses who work in maternity nurseries or newborn intensive care units.

This up-to-date, detailed text is divided into three parts.

The first section discusses normal development and physiology of the fetal and newborn lung. Subheadings cover the topics of intrauterine respiration in the fetal lung, the aeration of the lung at birth, perinatal circulation, the regulation of respiration, methods of study of pulmonary function in infants, and roentgenographic evaluation of the chest.

Part II outlines the disorders of respiration in the newborn period, including congenital anomalies, infections, aspiration syndromes, and persistent pulmonary dysfunction in premature infants. This section has an informative chapter on hyaline membrane disease and other conditions associated with hyaline membranes.

In the last section, the doctor talks about artificial respiration. Topics discussed included recuscitation at birth, infants at special risk at birth, evaluation of the newborn (APGAR rating), and criteria for recuscitation and the techniques of recuscitation.

Dr. Avery states that the intent of the clinical summary in the text is to stress that there are many causes of respiratory distress in the newborn period; she goes on to say that the most likely diagnosis can be suspected from the history and by inpection of the infant. The most helpful diagnostic aid is the chest film.

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Two New Catalogs

A new *Handbook of Educational Material for Guidance, Health, and Sex Education* has been prepared for schools. The 16-page catalog lists filmstrips, slides, films (16mm), and film loops (Super 8 or Standard 8). The audiovisual materials are available for purchase to aid in instruction or guidance, health, and family life education for teenage audiences.

Nursing educators may wish to be familiar with these aids as high school students entering nursing will likely have seen some of these materials. Public health nurses will be interested in knowing of new audiovisual aids for use in schools. Some of the materials may be suitable as aids in anatomy and physiology lectures in diploma programs.

Requests for the catalog should be sent to McIntyre Educational Materials Ltd., at 3333 Metropolitan Blvd. East, Montreal 455, P.Q. or at 123 Eglinton Ave. East, Toronto 12.

Davis and Geck has released a November 1968 supplement to its *Surgical Film Catalog.* The catalog lists new additions to the Davis and Geck Surgical Film Library.

One of the new films, entitled"Sychronous Combined Resection of the Rectum," was filmed in Canada at two Toronto hospitals. It describes details of a two-team abdomino-perineal resection for carcinoma of the rectum.

Davis and Geck Surgical Film Library loans medical and nursing films to Canadian hospitals and educational facilities; the library has some 250 subjects with approximately 1,300 prints available. Further information about the films may be obtained by writing to Davis and Geck Film Library, c/o P.O. Box 1039, Montreal 3, Quebec. □

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No more than *three* titles should be requested at any one time.

BOOKS AND DOCUMENTS

1. *Analyzing and reducing employee turnover in hospitals.* New York, United Hospital Fund of New York, Training Research and Special Studies Division, 1968. 94p.

2. *An approach to the teaching of psychiatric nursing in diploma and associate degree programs: a method for content integration and course development in the curriculum* by Joan E. Walsh and Cecilia Monat Taylor. New York, National League for Nursing, 1968. 78p.

3. *L'avortement* par Serge Mongeau et Renée Cloutier. Montréal, Editions du Jour, 1968. 173p.

4. *The challenge of changing patterns; report of the first conference of National League for Nursing Western Region Committee on Community Nursing Service. San Mateo, Calif., Mar. 22-23, 1968.* San Francisco, 1968. 46p.

5. *Clinic nursing: explorations in role innovation* by Herman Turk and Thelma Ingles. Philadelphia, F.A. Davis Co., 1963. 192p.

6. *Cooper's nutrition in health and disease* by Helen S. Mitchell et al. 15th ed. Philadelphia, Lippincott, c1968. 685p.

7. *Emerging sectors of collective bargaining.* Montreal, McGill University, Industrial Relations Centre, 1968. 120p.

8. *Etudes sur le parler français au Canada.* Préparé par La Société du Parler français au Canada. Québec, Les Presses Universitaires Laval, 1955. 220p.

9. *Fate, hope and editorials; contemporary accounts and opinions in the newspapers 1862-1873,* microfilmed by the CLA/ACB microfilm project by Helen Elliot. Ottawa, Canadian Library Association, 1967. 190p.

10. *The graduate education of physicians* by the Citizens Commission on Graduate Medical Education. Report commissioned by the American Medical Association. Chicago, American Medical Association, 1966. 114p.

11. *Guidelines for discharge planning* by Janis H. David, Johanne E. Hanser and Barbara W. Madden. Downey, Calif., Attending Staff Association of Rancho Los Amigos Hospital, c1968. 52p.

12. *Health care needs; basis for change. Papers of the first regional conferences.* New York, National League for Nursing. Council of Hospital and Related Institutional Nursing Services, 1968. 63p.

13. *History of nursing* by Josephine A. Dolan. 12th ed. Philadelphia, Saunders, 1968. 380p.

14. *Hospital safety and sanitation with special reference to patient safety.* Michigan, University of Michigan, School of Public Health, c1962. 208p.

15. *The Merck Index; an encyclopedia of chemicals and drugs.* 8th ed. Rahway, N.J., Merck & Co., 1968. 1713p. R

16. *Pharmacology and drug therapy in nursing* by Morton J. Rodman and Dorothy W. Smith. Philadelphia, Lippincott, c1968. 738p.

17. *The photography of H. Armstrong Roberts.* Philadelphia, 1968. 96p.

18. *The physician* by Russel Lee, Sarel Eimerl and the editors of Life. New York, Time Inc., c1967. 200p.

19. *A practical style guide for authors and editors* by Margaret Nicholson. 1st ed. New York, Holt, Rinehart and Winston, c1967. 143p.

20. *Professionalism and salaried worker organization* by Archie Kleingartner. Milwaukee, Wisconsin, Industrial Relations Research Institute, University of Wisconsin, 1967. 113p.

21. *Psychiatric nursing in general hospitals. Proceedings of the Canadian Conference on Nursing in Psychiatric Divisions of General Hospitals, First, Montreal, November 1958.* Montreal, McGill University, 1958. 84p.

22. *Questions and answers about contact lenses* by Barnes-Hind Pharmaceuticals, Inc. New York, Dell, 1968. 64p.

23. *Report of the Nursing Seminar, Teheran, Iran, 9-19 November 1966.* Alexandria, World Health Organization, Regional Office for the Eastern Mediterranean, 1968. 50p.

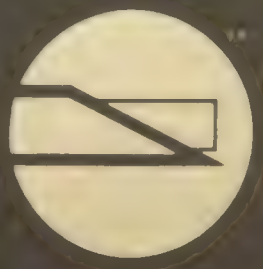
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ment and Research Foundation, 1965/67. Toronto, 1968. 209p.

25. *Reports to the general annual meeting, 44th.* Toronto, Ontario Hospital Association, 1968. 66p.

26. *Résumé du rapport (par G.M. Weir) de l'enquête au sujet de la formation des gardes-malades au Canada.* Préparé par le docteur Alfred T.- Bazin. Traduit par le docteur J.-A. Baudouin. Montréal, Autorisé par le Comité de Régie de l'Association des Gardes-Malades Enregistrées de la Province de Québec, 1932. 136p. **R**

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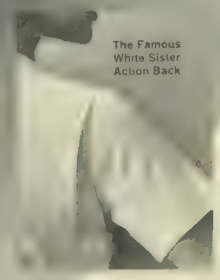


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Volume 65, Number 2 February 1969

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Editorial

Parliament's approval of Bill C-116, which, among other things, excludes professional publications from the benefit of second class mailing privileges ("News," p.7), came as a shock, if not as a surprise.

For the Canadian Nurses' Association, whose publications THE CANADIAN NURSE and *L'infirmière canadienne* probably will be affected by this new legislation, the postal boost comes at an inopportune time: CNA just does not have the money in this 1968-70 biennium to pay any additional mailing costs.

At present, the combined cost of the two journals to each CNA member is $3.00 yearly. That is, out of the $10 paid to CNA by each member annually, $3.00 is put aside for the operating expenses of the two journals. (In provincial associations whose membership exceeds 20,000, the annual fee per member in the 1968-70 biennium is $6.)

This is anything but an exorbitant cost for the publication of two professional journals. In fact, it is a minuscule amount when compared with the budget of other monthly publications of a similar size and nature.

When the new postal rates are increased this April, annual mailing costs of THE CANADIAN NURSE and *L'infirmière canadienne* will probably increase by $1.80 *per member*. In other words, the total costs of the two journals to each CNA member will rise from $3.00 yearly to $4.80.

This month, the CNA Board of Directors will examine the journals' financial plight and decide on the action to be taken. We believe that a special general meeting should be called to ask for an increase in the CNA membership fee. If CNA members believe there is value in having an Association journal, they must be willing to pay for it. — **V.A.L.**

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Back seat for human rights

At one time a nurse was an administrator of her own domain, in complete control, and completely responsible. She did rounds with the doctor and carried out his orders from a notebook with amazing precision. Most nursing care was a challenge to her and a satisfactory day's work. She used her own intuition and maturity coupled with common sense and experience.

Today, science has advanced and the law is enforced. Human rights have taken a back seat and money and status have taken a front seat. The nurse has only to try and read the doctor's orders, sign her signature 50 times per day, and make sure it is the right one. She has to keep closed lips to abuse and misuse and smile like an idiot.

Qualifications 1921: a registered nurse obtained a hospital diploma with assurance, professional pride, and respect. Qualifications 1968: a registered nurse has the aim of a university degree at some state of senility and has a well informed theory of non-professional status until she reaches that stage. – C. Mooney, Vancouver.

Needed: PR expert

I take exception to the letter in the November issue in which a B.C. nurse criticized Monica Angus' article in the August issue.

Surely this is what the provincial organizations of nursing have needed for years: if not a paid president, a paid public relations expert.

In this day of rapid communications, immediate explanation of events stated precisely at the height of public interest is mandatory. Only a well-paid public relations expert, well informed about the nurses' stand on financial matters especially is able to give nurses rapid, intense results. As an R.N. of 14 years and a member of the Registered Nurses' Association of Ontario, I cannot agree that senior staff members are cognizant of the problems of the staff nurse; if they are aware, they are too inarticulate or browbeaten by years of passive nurse-doctor relationships to fight for anyone.

As examples, instances this past summer and fall when a "public relations" expert would have been useful are cited:

1. An article in the *Globe and Mail* about staff shortage at the new Scarborough Hospital, the use of part-time staff, and foreign nurse employment.

2. The public health nurses' stand in Scarborough was broadcast on the national news. Surely a follow-up on an afternoon women's show could have been attempted.

3. The closing of a wing of a London hospital.

4. The phasing out of small hospitals to make way for a regional hospital in the Grey County area. Ontario Hospital Commission members were interviewed, but where were the nurses?

5. The recent hospital association meeting initiated snide remarks about hospital costs and staff expenses. Would the public not support us if they knew an R.N. has a take-home pay of less than many postal workers?

6. The atrocious reporting on the Canadian Nurses' Association meeting. Probably the delegates were too ashamed to be interviewed about basic minimum salaries, since they couldn't agree on $7,000.

7. The Commission on the Status of Women, deprecated on some television shows, for example, Hamilton Hot Line. Did any R.N. phone in or write to the announcer?

8. The recent announcement that nursing instructors' salaries would be decreased in the London area.

We need an aggressive, articulate, well-paid woman to communicate on many subjects. A national CNA expert could probably be utilized more economically than nine provincial ones. We need coverage immediately, not one or three months after a nurses' meeting. Preferably, our representative should not be an RN. Let's do better if we are going to have any girls in nursing 10 years from now. – R.N., Ontario.

A nurse never stops working

People often say: "Isn't that too bad. She just graduated from nursing, now she's getting married, and soon she will stop working to have a family." Little do they know how far they are from the truth!

I graduated and got married in August 1965. I worked in a newborn nursery for a year, took a postgraduate course in the care of the premature infant, and worked in a premature intensive care unit for another year. After that, my husband and I adopted a baby and I stopped working or so I thought!

No sooner had I settled down to the routine of staying at home, than people in the apartment, knowing I was a nurse, started calling.

First case – a large sty in a little girl's eye. "Should I compress it?" asked the mother. "Should she stay home from school?" After consulting my trusty medical-surgical book, we decided what should be done.

Soon after that, I was asked to remove a splinter from a little boy's foot and a tiny bug trapped in the corner of his sister's eye. Other questions were: "What should I give my husband for his cold?" "My baby is constipated. Is it all right to put brown sugar in the formula?"

Often friends would call and ask questions about a relative's illness. "How long will he be in hospital?" or "Why did this happen?" I always had to be careful to find out what the doctor had told them and then try to enlarge on this.

Several friends had premature babies. I usually sent a note with some helpful hints for when the baby came home about feedings, burping, clothing – things that nurses sometimes forget to tell these mothers and that the mothers never think of asking about.

I think every nurse in the community, whether she works in a hospital or not, never really stops nursing. She is constantly giving advice, answering questions, and bandaging cut fingers. She must, at all times, have a handy supply of gauze, tape, alcohol, and iodine, both for her own family and all the neighbors.

Ask any housewife/mother/nurse and she will tell you: "My work is *never* done!" – Ruth Smellie, R.N., Calgary.

Afraid to criticize

We are bitterly disappointed in Mr. Wedgery's letter in the December issue. We all know where the profession is going – downhill fast. This is mainly due to poor economic status, but it is also increased by hospital administrators who want to decrease hospital budgets, doctors who carp and criticize and have little empathy with the nurse, and encroaching paramedical "professions" poorly trained but cheaper to pay as inhalation therapists.

We are attacked in the hospital field and deserted by university colleagues who produce courses dealing in abstract sociological philosophies and semantics, and lack clinical data.

We are clinical practitioners, be we in the hospital or public health field. We need pertinent medical data. The hospitals are not giving enough inservice edu-

letters

cation to active nurses much less to semi-retired nurses. That is why we go to doctors' lectures. We need facile, succinct lectures.

Why don't we attend meetings airing the ills of nursing? No nurse working in a hospital dares initiate any criticism at chapter meetings; the directors are sitting there glowering. Possibly one solution would be to divide meetings into groups of peers – a sad commentary on nursing, but too true.

If Mr. Wedgery really wants to promote nursing discussion on the profession, he should start group discussions on topics such as how can *you* – at this hospital – increase nursing salaries? But he should not criticize nurses interested in doctors' lectures. This is the mark of a profession: we are interested in growth and education. – Three Ontario R.N.'s.

Tender loving care

Is T.L.C. passé? Having been on the receiving end of nurses' professional services in various hospitals this past year I feel more than qualified to say how ashamed I am to call myself an R.N.

Today's nurse seems more turned inward, concerned about working hours, salaries, vacations, and directing others to do her job. She has no time to help the multiple sclerosis patient on or off the bedpan, or give the necessary back care or mouth care. She is too busy for five-minute kindness. "Someone else will be in shortly" is an expression heard frequently. The paralyzed patient has tears running down her cheeks because the nurse takes too long with the necessary analgesic asked for one-half hour ago and she thinks she is forgotten. This could be you someday – a person in need whom no one seems to hear. Are you guilty of not caring? – Joyce Mossop, R.N., Thetford Mines, Quebec.

Book about nurses

I am preparing a book which will be a collection of short humorous stories about nurses and patients in hospitals, offices, and any other place where nurses come into contact with their patients.

I would appreciate it if nurses would send me stories of humorous incidents that have happened to them and I will include them in my book.

Fifty percent of the proceeds will be pledged to Oxfam Relief of Canada and the remainder of the proceeds will, I hope, cover my expenses.

Nurses may send jokes, short stories, or incidents to me at: 5830 Cote St. Luc Rd., Apt. 2, Montreal 253. – Dawn Moynihan, R.N. □



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news

Postal Rate Increases May Affect CNA Magazines

Ottawa. – Mailing costs for the Canadian Nurses' Association's magazines, THE CANADIAN NURSE and *L'infirmière canadienne,* may increase by more than 15 times the present costs when the new mail rates and classifications go into effect April 1, 1969. "If the magazines are required to pay the new third class rates, then the monthly costs of sending the magazines will rise from $770 to $11,072 for an average-sized issue," said Ernest Van Raalte, CNA General Manager. "Postage on returned journals and other direct mail costs would bring the total monthly postage to approximately $12,000," he said.

"The new rates, if applicable to CNA magazines, would mean that an additional $135,000 would have to be found in this year's present CNA budget," Mr. Van Raalte said. "CNA has applied for exemption from this increase, but word from the Post Office Department has not yet been received."

The Association, which agreed to hold its budget for the 1968-70 biennium to the 1966-68 figures, does not have the money to cover these increases without a major cutback in some other of its planned expenditures, Mr. Van Raalte told a reporter for THE CANADIAN NURSE The Board of Directors and the special Ad Hoc Committee on Functions, Relationships, and Fee Structure have been notified about the new rates and the possible effects, he said. This will enable the Board to make an interim decision about financing these additional costs at its meeting in February, he added, and the special committee, which was set up at the biennial meeting to investigate the questions of fees and the division of labor between the provincial and national associations, can consider this additional financial problem before submitting its report.

Helen K. Mussallem, executive director of CNA, says that if CNA has to pay the increase, she can see only three possible solutions. "We can cut back the present CNA programs to find the additional $135,000, or we can cut back and modify the present form of the CNA magazines, although that may mean a loss of advertising revenue; the only other alternative would be to raise the money through increase of CNA fees at the next general meeting," she said. She pointed out that the Board will probably debate these alternatives at the Board meeting beginning in Ottawa, February 11.

Several other professional journals are also facing the problem of the increased postal rates. Arthur Kelly, managing editor of the *Canadian Medical Association Journal,* was quoted in an Ottawa paper as saying that to continue, the *CMAJ* might have to become a monthly or semi-monthly publication, rather than continue as a weekly. Dr. Kelly said that he expected postal fees for the *CMAJ* to increase to $140,000 a year from the present $18,000.

When Postmaster General Eric Kierans introduced Bill C-116, which included the changes in mail rates and classifications, he explained that the changes in respect to newspapers and periodicals had two main objectives, says a release from the Post Office Department. "The first is to take a long step toward assuring that second class mail pays its fair share of postal costs. The second objective is to modify and clarify the terms and conditions under which the statutory second class rates apply and thereby establish a more logical basis for determining entitlement to second class privileges," says the release.

These changes are mainly to exclude non-profit associations, which do not pay taxes, from qualifying for second class mail privileges.

Canadian Printer & Publisher, the magazine of the Canadian printing industry, quoted the Postmaster General as saying, "Over the past 10 years alone, the Canadian public has disbursed a total of approximately $300 million to publishers by way of a subsidy on second class mail rates."

The magazine goes on to point out later that two magazines, *Time* and *Reader's Digest,* both U.S.–owned and with low editorial costs because most of the material is shipped from the U.S. parent, will continue to enjoy the low rates and large subsidies.

CNF Scholarship Fund Drops To $25,000 For 1969

Ottawa. – The Canadian Nurses' Foundation reports that approximately $25,000 will be available for 1969 fellowship awards, less than half the amount awarded in each of the past two years.

As of August 31, 1968, the balance in the scholarship fund was $13,000, and in the general fund $11,000. As all administrative costs are met by the Canadian Nurses' Association, a transfer of $10,000 from the general to the scholarship fund will be considered at the annual general meeting at CNA House, February 11. Any significant donation before May 1 could increase the amount available for scholarships.

Two provincial organizations have announced their intention to make annual grants to CNF. The Registered Nurses' Association of British Columbia will make a per capita grant to the Foundation, the amount to be decided each year. The Alberta Association of Registered Nurses will contribute $1.00 per member each year.

Membership in the Foundation stood at 1,494 in August, 1968. Donations amounted to a total of $16,366 at the same date, including donations by individual members, provincial associations, and other groups.

The general meeting in February will also consider reports of the Board of Directors, the secretary-treasurer, auditors, and committees, and discuss the establishment of the calendar year as the financial year of the Foundation.

Special Ad Hoc Committee Meets

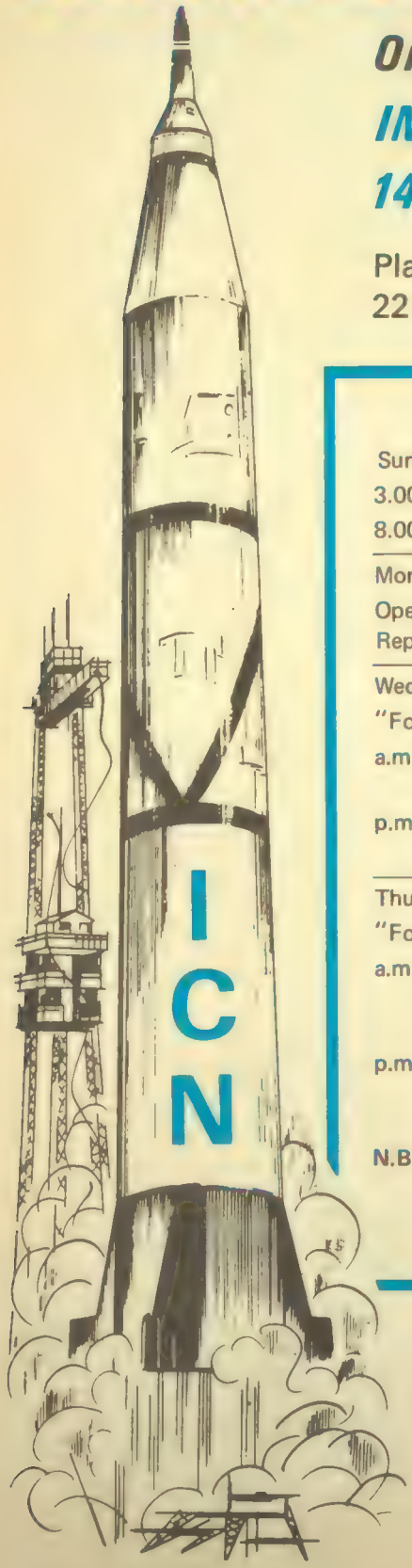
Ottawa. – The first meeting of the special Ad Hoc Committee on Functions, Relationships, and Fee Structures was held at CNA House January 9 and 10, 1969. The committee, generally dubbed the "Special Committee," was set up at the biennial general meeting of the Canadian Nurses' Association last June after considerable discussion on the questions of fees and of the divisions of labor and responsibilities between the provincial and national associations.

Chairman Jean S. Tronningsdal told THE CANADIAN NURSE after the meeting that the committee has spent two very busy days and has made a good start. "We have a lot to do in a short period of time," said Mrs. Tronningsdal, "and we realize that we will have to pace our efforts. We must finish our task by January 1970, so that the provincial associations can receive and study our report before the biennial meeting in June 1970," she explained.

During the meeting, committee members agreed to appoint a secretary from the group on a rotating basis, Mrs. Tronningsdal said. Madge McKillop, University Hospital, Saskatoon, was given the task for this meeting. Marie Sewell, New Mount Sinai Hospital, Toronto, will

(Continued on page 9)

COUNTDOWN TO CONGRESS



Only four months to go to the INTERNATIONAL COUNCIL OF NURSES' 14th QUADRENNIAL CONGRESS

Place Bonaventure, Montreal, Canada,
22 to 28 June, 1969.

PROGRAM HIGHLIGHTS:

Sunday, 22 June
3.00 p.m. Interfaith Service
8.00 p.m. Opening Ceremony

Monday and Tuesday, 23 and 24 June
Open meeting of Council of National Representatives (CNR)

Wednesday, 25 June
"Focus on the Future"
a.m. Plenary session —
Forecasting the Future
p.m. Plenary session —
Implications of Change

Thursday, 26 June
"Focus on the Future"
a.m. Plenary session —
Education for Today and Tomorrow. Basic Programs
p.m. Plenary session —
Education for Today and Tomorrow. Post Basic and Postgraduate Programs
5.00 p.m. Voting for ICN Officers by CNR
8.00 p.m. Students' Congress

Friday, 27 June
"Focus on the Future"
a.m. Plenary session —
Security for Tomorrow
p.m. Plenary session —
Leadership in Action
8.00 p.m. Closing Ceremony
Admission of new member associations to ICN
New ICN Officers announced

Saturday, 28 June
Canada Hospitality Day.

N.B. * Special Interest Sessions — 19 topics in English and French, will be running Monday through Friday
* International Nursing Exhibition — runs Monday through Wednesday

FOR FURTHER INFORMATION, INCLUDING REGISTRATION KITS, PLEASE WRITE TO:

ICN Congress Registration,
50, The Driveway,
Ottawa 4, Ontario.

(Continued from page 7)

take on the secretarial duties at the next meeting.

Mrs. Tronningsdal said that the next meeting of the committee has been set for May 8 and 9, 1969, at CNA House. In the meantime, the committee well seek information on certain specific matters from the provincial associations, the CNA, and CNA permanent staff members.

Members of the committee include: Mrs. Tronningsdal, Miss McKillop; Miss Sewell; K. Marion Smith, Vancouver; Madeleine Jalbert, Quebec; Marilyn Brewer, Fredericton; Dorothy Wiswall, Halifax; Sister Mary Irene, Charlottetown; and Elizabeth Summers, St. John's Nfld. Sister Mary Felicitas, president of the CNA, is a member ex-officio. All members attended the meeting.

An interim progress report will be presented to the CNA Board of Directors meeting in February, Mrs. Tronningsdal said.

Several Reasons For Drop In Enrollment, Says RNANS

Halifax. – Nova Scotia newspapers recently reported critical drops in the student nurse enrollment in the provincial nursing schools. Figures from the Registered Nurses' Association of Nova Scotia support the reports. Only 264 students registered in diploma schools this year, compared to 430 last year, reported Gertrude Shane, RNANS public relations officer.

"However, there are several reasons for the decrease," Mrs. Shane added. "Although emphasis has been placed on the raising of standards, other factors are involved," she said.

Michael MacDonald, director of the Nova Scotia Hospital Association, was quoted in the press saying that the entrance standards, raised this year by RNANS, had contributed to the drop.

RNANS raised the educational requirement for entrance to a school of nursing to grade 12 (equivalent to senior matriculation) from grade 11. Mrs. Shane explained that this was part of an overall program to improve nursing education in the province.

RNANS has published several studies calling for reforms in nursing education during the past few years. Recommendations included the phasing out of diploma schools with less than 40 students, the adoption of a two-year program, improved curricula, and other changes. In Sydney, N.S., five hospital schools have suggested amalgamation into a central school. This would make better use of existing facilities and of qualified faculty.

She said that nursing must compete for the best students with other professions, such as teaching, social work, and paramedical fields. Greater numbers of students are entering the university program. Requirements now are the same for both the diploma and the degree courses in the province.

Another factor in the drop in enrollment in the nursing schools might be the low pay rates for nurses in the province, Mrs. Shane said. "Young women of the kind we need at the bedside are aware that salaries in nursing are lower than in other fields. Dedication alone will not attract the caliber of student who can cope with today's medical advances and modern hospital techniques," she said.

Mrs. Shane added that the executive of the Association is concerned about the drop and will consider all aspects of the matter at its next meeting.

UR a PR for ICN, Says PRO



Ottawa. – "Every Canadian nurse will need to be a public relations officer, if the International Council of Nurses Congress is going to succeed," Valerie Fournier, public relations officer for the Canadian Nurses' Association told her provincial counterparts at a recent meeting in Ottawa. The public relations officers from the 10 provincial associations had gathered in Ottawa December 12 and 13, 1968 for a meeting devoted almost exclusively to discussions on public relations for the forthcoming ICN Congress in Montreal in June. The PROs were shocked at the low registration of Canadian nurses for the Congress.

The PR Conference, the second which has brought public relations counterparts from all the provinces to Ottawa, discussed ways and means of promoting ICN in the provinces, and other matters, including division of duties between CNA and provincial PROs, when to start sending information to local media, and the organization of the press rooms at ICN.

B.J. McGuire, of Forster, McGuire, Ltd., PR consultant to CNA and in charge of public relations for the ICN Congress, said that 100 to 150 media people, representing TV, radio, newspapers, wire services, magazines, and nursing press, are expected to be seeking information during the Congress. He explained the tentative plans for press facilities, and indicated areas where qualified public relations people would be needed. Six provinces have offered to send their public relations staff member to Montreal to assist CNA with staffing press rooms during the Congress. Peter Regenstrief, newspaper columnist, TV communicator, and professor of political science at the University of Rochester, Rochester, N.Y., was guest speaker during the Thursday afternoon session.

Registration Picks Up As Cut Off Date Nears

Ottawa. – Canadian registration for the forthcoming Congress of the International Council of Nurses picked up rapidly as the deadline for full registration approached. Harriet Sloan, the Canadian Nurses' Association's coordinator for the ICN Congress, reported that as of January 10, 1969, 756 Canadians had registered for the international meeting.

"This is nowhere near the 2,000 Canadians that we expect will be registered by June, but it is picking up rapidly now,"

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news

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Miss Sloan said. "However, it does represent a jump of 286 during the week from January 3 to 10," she said.

The last day for full registration privileges was January 22. Nurses can still register, Miss Sloan points out, but the fee has risen from $40 to $60.

Breakdown of registration up to January 10, 1969 is:

British Columbia	54
Alberta	44
Saskatchewan	16
Manitoba	34
Ontario	280
Quebec	247
Nova Scotia	11
New Brunswick	29
Prince Edward Island	2
Newfoundland	1
	718
Students	38
Total	756

CNA Sends Suggestions To Task Force on Information

Ottawa. – In answer to a request from the federal government's Task Force on Government Information, the Canadian Nurses' Association submitted four suggestions in December for improving the government's information services.

Helen K. Mussallem, executive director of the CNA, made the suggestions in a letter to D'Iberville Fortier, chairman of the Task Force. In it she said that the government information services should have facilities and personnel to:

- collect and publish data relevant to the supply of adequate nursing personnel for the long-term needs of Canadians;
- produce and disseminate information on the nursing profession for the use of high school guidance counselors and others to encourage the entry of students into the profession;
- respond to enquiries from foreign nurses regarding emigration to Canada to practice nursing;
- notify CNA about planned government activities concerning nurses to encourage participation by nurses and to minimize duplication of effort.

The Task Force on Government Information, which will submit its recommendations by March 1, 1969, was commissioned to study the structure, operation, and activities of federal departmental information organs in Canada and abroad. It will make recommendations to the government on ways communication can be improved by the government's information services.

AV-AIDS For Nursing Subject Of US Study

New York. – A survey to provide information about audiovisual materials available for nursing is underway in the United States. The study, which will help the American Nurses' Association-National League for Nursing Film Service, is supported jointly by the U.S. Department of Health and the two nursing associations.

The Health Department will provide $49,056 to the study for one year and the nursing organizations will contribute $8,930, bringing the total amount for the project to $57,986.

A survey questionnaire will be sent to users and producers of nursing audiovisual materials. It will concern 16 mm and 8 mm film, filmstrips, videotapes, slides, audiotapes, computer instruction programs, and recordings. A list of all materials reported and a list of those recommended for use in schools of nursing and health agencies will be prepared.

OR Nurses Discuss Infection in Hospitals

Montreal. – Asepsis was the main topic of discussion at the tenth annual meeting of the Operating Room Nurses of Quebec, held October 30 and November 1, 1968, in Montreal.

Lucette Lafleur, bacteriologist at L'Hôpital Sainte-Justine, René Roux, surgeon at l'Hôtel Dieu, Montreal, and Claude Morin, clinical instructor at L'Hôpital Notre-Dame, Montreal, participated in a panel discussion entitled "Asepsis in the Operating Room." A question and answer period after the panel presentation enabled the audience to participate.

Dr. Lafleur attributed the recurring problem of infection to the increasing numbers of new operations, such as neurosurgery, spare parts surgery, and some heart surgery. She suggested several methods for improving techniques, including use of hexachlorophene or detergent in cleaning and, when possible, fumigation of the theatres. Contamination of air in the operating rooms depends on the number and length of the operations, she said, adding that it would be necessary to remove all air from the room to sterilize

(Continued on page 14)

Sub-Committee On Occupational Health Meets in London



London, England. – The first meeting of the Nursing Sub-Committee of the Permanent Commission and International Association on Occupational Health was held in London, October 21 to 26, 1968.

The Sub-Committee was established in Vienna in 1966, to gather information on the preparation and experience of occupational health nurses throughout the world, and to prepare reports to help countries raise standards of occupational health nursing. Reports of the meetings will be presented at the sixteenth congress of the Permanent Commission and International Association on Occupational Health in Tokyo in September, 1969.

The Permanent Commission and International Association on Occupational Health was established in 1906 in Milan, Italy, and for many years remained an organization of specialist physicians. Nurses were invited to present papers to its meetings for the first time in 1948, but it was not until 1963 that the first Canadian nurse member was accepted. By 1968 there were four Canadian nurse members.

The London meeting of the Nursing Sub-Committee raised its membership to six from the five established in Vienna by admitting another American member. From left to right they are: Ruth Sayanjarvi (Finland), Sally Wagner (USA), Mary Blakeley (UK), Sarah Wallace (Canada), Gunnell Pramberg (Sweden), and Mary Louise Brown (USA).



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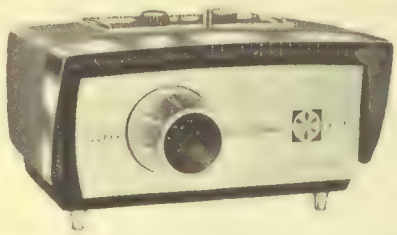
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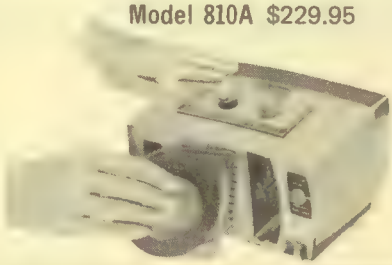
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CNJ /69

ARNN Moves To New Headquarters



St. John's. – Staff of the Association of Registered Nurses of Newfoundland have moved into their new building in Central St. John's and are making preparations for the official opening to take place early in April. The new offices, adapted from a two-story family home, were purchased last fall by the ARNN at a cost of $35,000.

The main floor has been altered into a large Board Room with an adjoining office for the president, a main office area for permanent, professional staff, and a general work area for secretarial staff. Upstairs, there are five rooms; one has been established as a library and one has been turned over to the Newfoundland Student Nurses' Association. The ARNN may rent the others until the space is needed.

"After our old, desperately-crowded quarters, the staff appreciate the larger amount of space," said Pauline Laracy, ARNN executive secretary. "It is pleasant to no longer have to stack boxes on top of boxes, or on the floor, or on desks, or anywhere space could be discovered."

The photograph shows the executive and staff in front of the new ARNN building on moving day last September.

UNM Elects New Officers



Montreal. – The United Nurses of Montreal elected new officers to the executive committee and board of directors at their annual meeting, November 29. Wendy D. Rogers (center), continuing UNM president, welcomes Mary Anne Adams (right), of The Montreal General Hospital, who was elected first vice president, and Monika Berlage, Montreal Children's Hospital, secretary.

Newly elected directors of the executive committee are: Audrey Crouse, Royal Victoria Hospital; Liz Ireton, Montreal Children's Hospital; and Janet Funke, St. Mary's Hospital.

Newly elected officers of the Board of Directors are: Carolyn Robertson, Montreal Neurological Institute, as first vice-chairman; Hilda Darlington, Lakeshore General Hospital, secretary; and Mary Costello, Montreal Children's Hospital, Shirley Alexander, Royal Victoria Hospital, and Colleen McGillvary, Jewish General Hospital, directors.

Margaret Masters, Jewish General Hospital, continues as chairman of the board of directors.

(Continued from page 10)

it completely. Some control of air contamination is obtained by limiting the number of people entering and leaving the operating room, and by restricting the number of unnecessary movements, and reducing talking to a minimum.

Dr. Roux suggested the operating area could be divided into three sections: an inner aseptic area that would be the operating theatre; an intermediate area for scrubbing; and an outer general exchange area. Entrance to any of these three operating areas would require a change to OR garb. Dr. Roux recalled the Canadian Hospital Accreditation Board's recommendations, and advised that each hospital study its own special problems of infection and particular needs. He also recommended the establishment of a committee to investigate the problem of infection in hospitals.

Miss Morin spoke of a plan to prepare nurses and other hospital personnel for their operating room tasks. She emphasized the need for knowledge of asepsis by all personnel in the hospital.

Montreal Nurses Sign Contract With Queen Elizabeth Hospital

Montreal. – A contract reducing the work week from 40 hours to 36-1/4 hours was signed by the United Nurses of Montreal and the Queen Elizabeth Hospital in Montreal, November 15, 1968. In addition to the reduced hours, nurses working on the night shift will have coffee breaks and one extra day off in every seven worked to compensate for the meal periods given in the day shift. A nurse in charge of a unit on evening or night shifts will receive an extra 65 cents per shift in addition to the premium for that shift.

The new contract also stipulates that credit for previous experience of a new employee will be determined on the basis of experience in nursing acquired in hospitals or in public health nursing within the past 10 years. The starting rate will be determined by completed years of experience. Annual increments will be given at the completion of each year of experience. The first annual increment will be given on the completion of an additional year, comprising months prior to employment by the hospital and those completed in the hospital. Future increments will be given on the anniversary of the date of this first increment.

The contract was negotiated by Wendy Rogers, president of UNM, and Margaret Stead, executive secretary. The UNM is a union of professional nurses formed in 1966 by the English Chapter, District XI of the Association of Nurses of the Province of Quebec.

Electronic Video Recording Simplifies Film Showing

New York. – A new method of storing and playing audiovisual material for

(Continued on page 16)

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(Continued from page 14)

hospitals, schools, and home has been introduced by the Columbia Broadcasting System. The Electronic Video Recording system stores 52 minutes of film in a cartridge seven inches in diameter, and is simple enough for a child to operate.

EVR records pictures and sound much as long-playing records store sound. The system consists of the thin film stored in the cartridge, and a player that transfers the sound and pictures to a standard television set.

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The EVR player is attached to the television antenna terminals by handclips. The cartridge is placed on the player, the television is turned to a channel that is not broadcasting, and the starter button pushed. The film is automatically threaded, and can be advanced or rewound rapidly, slowed for careful viewing of a particular scene, or frozen altogether. The system can be operated in normal light, and there is no projector noise to distract viewers.

Hospitals and schools are expected to be among the first purchasers of EVR because of its value in education. It will make films easier to show and store, and, since it can be operated in normal light, notes can be taken from the films. The same film can be hooked to several television sets, so that a large number of students can see the films.

Although EVR was developed by CBS as an offshoot of the space research it is conducting for the US government, the system will be manufactured by Motorola Inc. Educational films will be handled by *The New York Times* Book and Educational Division.

The first black and white model of EVR should be ready for the market by July, 1970. The first color model is expected to be produced by the second half of 1971. Exact costs of the system have not yet been announced.

U. of M. Graduates Form Alumni Association



Montreal. – Graduates of the University of Montreal Faculty of Nursing met November 2 and 3, after the annual meeting of the Association of Nurses of the Province of Quebec, to form an alumni association. The meeting, held in the auditorium of city hall, had been planned since July. After considerable debate, it was agreed that graduates of l'Institut Marguerite d'Youville, which became part of the University of Montreal in June 1967, would be able to become members. Officers elected at the meeting are, left to right: Huguette Pelland, treasurer; Claudette Beauchemin, vice-president in charge of public relations; Ginette Roger, president; Sister Denise Lafond, secretary-archivist; Sister Rachel Rousseau, secretary-registrar. Absent is Lisette Arcand, vice-president.

Work Progressing For Standardized Terminology

Ottawa. – The National Working Party on Standardization of Terminology in Hospitals has continued to hold bi-monthly meetings since its inception in February 1968.

The Working Party was established under the sponsorship of the Department of National Health and Welfare and the Canadian Hospital Association to develop standardized terminology relating to various aspects of hospitals and hospital personnel. Its 15 members come from the Dominion Bureau of Statistics, various professions, hospitals, and provincial hospital insurance plans throughout the country.

Donald F. Moffatt, consultant in hospital administration with the Department of National Health and Welfare, and chairman of the Working Party, told THE CANADIAN NURSE that he expects a glossary of terms to be produced in about a year. The Working Party has held five three-day meetings so far.



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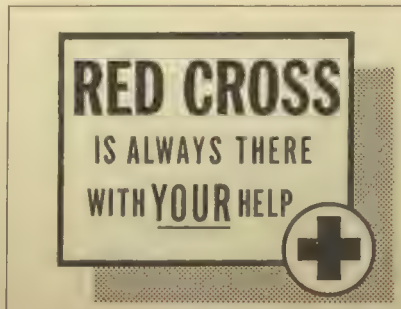
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names



Margaret E. Steed (Reg.N., Toronto Western H.: Cert. Teaching & Superv., B.N., McGill U.; M.A., Columbia U., New York) has been appointed by the University of Alberta as consultant to schools of nursing in Alberta.

Prior to this appointment, Miss Steed was consultant in education, Canadian Nurses' Association, a position she held from 1964 to 1968. As education consultant, Miss Steed visited schools of nursing all over Canada on a consulting basis. She also served as secretary for the International Council of Nurses Exchange of Privileges program that sponsored international nurse visits.

In her new position, Miss Steed replaces Marguerite Schumacher, now director, department of nursing education at Red Deer Junior College, Alberta. Miss Steed will be responsible for consultations and visits to schools of nursing in Alberta, and for organizing workshops and continuing education programs for nurses and nursing instructors.

Miss Steed taught for many years in the school of nursing at Toronto Western Hospital. From 1956 to 1962 she was assistant director of nursing at Kitchener-Waterloo Hospital.

Sister Elizabeth F. Hurley (R.N., St. Joseph's H., Saint John, N.B.; B.Sc.N., Seattle U., Wash.) recently was appointed director of nursing service at St. Vincent's Hospital in Vancouver. Sister Elizabeth formerly worked as a staff nurse at St. Joseph's Hospital in Saint John, New Brunswick and as supervisor at St. Vincent's Hospital in Vancouver.

M.Kathleen Logan (R.N., St. Joseph's H., Saint John, N.B.; Dipl. Teaching, B.N., Dalhousie U.) has been named assistant director of nursing at St. Vincent's Hospital. Miss Logan formerly worked as general duty nurse at St. Joseph's Hospital, Saint John, New Brunswick and in the Montreal Neurological Institute.

Margaret Isobel Schaap (R.N., Regina General; Cert. Teaching & Superv., U. Manitoba) is the new director of nursing at Winnipeg Municipal Hospital. Previous to her appointment, Mrs. Schaap worked at Municipal Hospital as a general duty and head nurse, and as assistant director of nursing. Mrs. Schaap has also held positions at Regina General Hospital, Ontario Hospital in Woodstock, St. Joseph's Hospital, Winnipeg, and the Shriners Hospital for Crippled Children in Winnipeg.

Florence M. Fleming (B.A., U. Alberta; R.N., Vancouver General; Cert. Nursing Service Admin., U. Toronto) education secretary of the Registered Nurses' Association of British Columbia since September 1964, retired on December 31, 1968.

After receiving her Bachelor of Arts (in Science) degree, Miss Fleming attended the Normal School in Calgary and taught in Alberta high schools for eight years.

For ten years after her graduation from The Vancouver General Hospital School of Nursing, she worked in that hospital first as a general duty nurse and later as assistant night supervisor and executive assistant in the department of nursing.

Miss Fleming was an instructor at The Vancouver General Hospital School of Nursing for 11 years before joining the RNABC professional staff.



Ruth E. McIlrath (R.N., Winnipeg General H.) has been appointed director of nursing at Shaughnessy Veterans Hospital in Vancouver. She joined the staff of the hospital as supervisor in May 1947 and became assistant director of nursing service in 1961.

After graduating from Winnipeg General Hospital School of Nursing in 1936, Mrs. McIlrath was a staff nurse and then supervisor in the maternity department of the hospital until 1941. She was a general duty nurse there until 1942, when she joined the Royal Canadian Army Medical Corps.

She served as a lieutenant nursing sister in army hospitals in the Pacific Command and on the Canadian hospital ship Lady Nelson. She went overseas as captain (assistant) matron with the No. 24 Canadian General Hospital. Following service in England, she served in Italy and Holland. Mrs. McIlrath served with the Corps until 1946 and was awarded the Associate Royal Red Cross Medal.



Glennis N. Zilm, assistant editor of THE CANADIAN NURSE since October 1964, left the staff at the end of January. She plans to do free-lance writing while she completes her final year of journalism at Carleton University this Spring. After that Miss Zilm's plans are uncertain, but she will be on hand to help the Canadian Nurses' Association's public relations team at the ICN Congress in June 1969.

A 1958 graduate of the combined nursing program at The Vancouver General Hospital and the University of British Columbia, Miss Zilm had considerable experience in nursing before joining the journal staff. Her experience included nursing administration in a small hospital in British Columbia, public health nursing in the School Health Service in Sydney, Australia, and clinical instruction at the Royal Columbian Hospital in New Westminster.

Miss Zilm has become well-known to many Canadian nurses during her four years as assistant editor. In both 1967 and 1968 she visited hospitals and public health agencies in all the Western provinces to explain the policies of THE CANADIAN NURSE and to encourage nurses to write articles for their national magazine. She gained many friends for

names

the journal during these visits, and was responsible for obtaining much interesting material for journal readers.

As a direct result of Miss Zilm's eagerness to obtain new information and to pass it on to other nurses, the "Idea Exchange" pages were born. Her creativity has been shown in many other ways, not the least of which are the "News" pages, the department that has become the most popular among readers. In addition, Miss Zilm has written many well-researched articles for the journal, one of which appears in this month's issue (p. 37).

The staff of THE CANADIAN NURSE and *L'infirmière canadienne,* as well as the readers of these magazines, will miss Glennis Zilm. We wish her well in her journalism career, wherever it may lead.

–V.A.L.



Several new staff members have joined the faculty of the school of nursing at The University of Alberta.

Alice R. MacKinnon (R.N., U. Alberta H., Edmonton; B.Sc., U. Alberta, M.N., U. Washington, Seattle) has been appointed assistant professor.

A native Albertan, Mrs. MacKinnon spent six years in the United States and Canada in public health nursing, education, and supervision. She returned to Edmonton to become principal of the School for Nursing Aides, a position she held for five years. During the next five years, she was associate director of nursing education at the school of nursing, Foothills Provincial General Hospital, Calgary. She is currently teaching nursing education in the postbasic degree, basic degree, and diploma programs.



Margaret Ann Beswetherick (R.N., Vancouver General; Dipl. Teaching & Superv., U. British Columbia; B.N., M.Sc., McGill U.) has been appointed assistant professor.

Miss Beswetherick began her career as a general duty nurse at The Vancouver General Hospital, following it with experience in a small hospital. After completing the diploma program in clinical supervision at the University of British Columbia, she became a member of the teaching staff of The Vancouver General Hospital for six years. She then attended McGill University, first to attain a bachelor of nursing degree in administration in hospitals and schools of nursing and later to obtain a master of science degree in nursing education and administration. She then served as associate director of nursing education at Kingston General Hospital for two years, leaving this to become nursing advisor to the Registered Nurses' Association of Nova Scotia. While in Nova Scotia, she served also as a consultant on nursing service for the Nova Scotia Hospital Insurance Commission.

She is currently teaching nursing administration.

Gloria C. Gehlert (R.N., U. Alberta H., Edmonton; B.Sc., U. Alberta) has been appointed lecturer.

After graduation, Mrs. Gehlert spent two years in Hawaii as a general duty nurse, returning to Alberta to take a public health nursing position with the City of Edmonton Health Department for two years. Following this, she served for a three-year period as a clinical instructor in medical-surgical nursing at the University Hospital, Edmonton and subsequently completed the postgraduate course in cardiology nursing there. She is presently teaching in the four-year basic degree program in the advanced medical-surgical area.



Sandra Arleigh Shanks MacDonald (R.N., Victoria Public H., Fredericton; B.N., Dipl. Teaching & Superv., Dalhousie U.) has been appointed lecturer.

Mrs. MacDonald has graduate nursing experience in both operating room and emergency departments in hospitals in the Maritimes. She is presently teaching in the basic degree program in the advanced medical-surgical area.

Marjorie Sandilands (R.N., U. Alberta H., Edmonton; B.Sc., U. Alberta) has been appointed lecturer. Following experience as instructor in pediatric nursing at the University Hospital, Edmonton, she is currently teaching maternal and child health and junior medical-surgical nursing in the basic degree program.



Leith Nance (R.N., Alberta H., Ponoka; B.N., McGill U.) has joined the faculty as lecturer in psychiatric nursing in the four-year basic degree program.

Prior to completing her degree at McGill, Miss Nance spent several years in general duty and teaching in Alberta, Hawaii, and Australia. Following this, she served as an instructor in psychiatric nursing at The Montreal General Hospital, leaving to join the World Health Organization with postings in Egypt and Burma.



Rene Oberholtzer (R.N., U. Alberta H., Edmonton; B.Sc., U. Alberta) has been appointed lecturer. Following experience in public health nursing with the city of Calgary Health Department, Mrs. Oberholtzer returned to the university to teach fundamentals and senior medical-surgical nursing in the basic degree program.



Frances Murphy (R.N., St. Paul's H., Vancouver; B.Sc.N., U. British Columbia) has joined the staff as lecturer in psychiatric nursing in the basic four-year degree program. Following general duty experience at St. Mary's Hospital in New Westminster, B.C., Miss Murphy held public health nursing positions with the Metropolitan Health Committee in Richmond, B.C. and with the Calgary Health Department. She leaves her position as clinical instructor in psychiatric nursing at the Royal Inland Hospital, Kamloops.

Joyce Sharpe (R.N., U. Alberta H., Edmonton; B.Sc., U. Alberta) has joined the faculty as sessional demonstrator.

Following two years of public health nursing in Alberta with the Sturgeon Health Unit, Mrs. Sharpe is presently concerned with the planning and supervision of public health nursing experience and related duties with the on-campus well child clinic for families of students attending the University of Alberta.

Carol Lynn McWilliam (B.N., U. New Brunswick) has been named clinical instructor at the University of New Brunswick School of Nursing. Mrs. McWilliam was formerly employed as a staff nurse at Victoria Public Hospital in Fredericton.

Doris D.N. Stevenson (R.N., Calgary General; B.Sc., U. Alberta; M.N., U. Washington, Seattle) has replaced Sister Marguerite Letourneau as director of nursing education at Holy Cross Hospital in Calgary.

Mrs. Stevenson was formerly assistant director of nursing at Rockyview Hospital in Calgary. She also worked for seven years at Medicine Hat General Hospital, Alberta, as clinical instructor and supervisor, science instructor, and associate director of nursing education. She spent one year at Royal Alexandra Hospital in Edmonton as science instructor and at the University of Alberta Hospital in Edmonton as a general duty nurse.

(continued on page 24)



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(Continued from page 22)



Frances May Moss (B.A., Dalhousie U.; R.N., Royal Victoria H., Montreal; Dipl. Teaching and Superv., Dipl. Admin., McGill U.) is the new executive secretary of the Registered Nurses' Association of Nova Scotia. Mrs. Moss leaves a position she has held for the past 13 years as instructor of medical-surgical nursing at Millard Fillmore Hospital School of Nursing, Buffalo, New York.

Mrs. Moss worked at Victoria General Hospital in Halifax for 13 years as assistant director and director of nurses. She also was an instructor at the Sydney City Hospital, Nova Scotia, and head nurse at Royal Victoria Hospital, Montreal.



Laveena Anne Gittins (B.Sc.N., U. Saskatchewan) has been appointed coordinator of the school of diploma nursing, Saskatchewan Institute of Applied Arts and Sciences. Mrs. Gittins has worked at Saskatoon City Hospital as a staff nurse and as an instructor; at the Saskatchewan Institute of Applied Arts and Sciences as instructor; and at Weyburn Union Hospital, Saskatchewan as head nurse.



The new director of the Algoma Regional School of Nursing in Sault Ste. Marie is **E. Jean Mackie** (R.N., Royal Alexandra Hospital, Edmonton; Cert. Teaching Superv., U. Toronto; B.N., McGill U.; M.N., U. Washington, Seattle). Miss Mackie was formerly chairman of the department of nursing education at Mount Royal Junior College, Calgary.

Miss Mackie has devoted her nursing career to education. She was nursing arts teacher for five years at the Royal Alexandra Hospital School of Nursing; clinical teacher at Calgary General Hospital for six years, and assistant director of nursing education for two; and medical-surgical nursing teacher at Everett Community College, Washington, for one year. ☐

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The Canadian Nurse

- Rare Blood Groupings
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dates

February 10-13, 1969
March 20-23, 1969
April 14-17, 1969
Regional conferences on the use of audiovisual aids in nursing, sponsored by the Registered Nurses' Association of Ontario. To be held in Sudbury in February, Ottawa in March, and Fort William in April. Fee: RNAO members, $25; non-members, $35. Write to: RNAO, 33 Price St., Toronto 5.

August 1968 - June 1969
The National League for Nursing is sponsoring a series of 12 two-day workshops in several U.S. cities for persons involved in administration, planning, and evaluation of hospital nursing services. The first workshop was held in San Francisco August 9, 1968, and the last will be held in Miami Beach, June 26-27, 1969.

The workshops are designed for nurses and others interested in nursing audits, new staffing patterns, and hospital staff development programs.

Further information and application forms for registration may be obtained from the Department of Hospital Nursing, National League for Nursing, 10 Columbus Circle, New York, New York 10019.

February 11-12, 1969
February 13-14, 1969
Workshops on "how to achieve better integration in the nursing program." First workshop to be held in Edmonton, second in Calgary. Conducted by Miss Dorothy Rowles, Ryerson Polytechnical Institute, Toronto.

February 17-19, 1969
Second Canadian Conference on Hospital-Medical Staff Relations, Chateau Frontenac, Quebec City. Theme: Better communications for better patient care. Sponsored by Canadian Hospital Association, Canadian Medical Association, and Canadian Nurses' Association.

February 24-27, 1969
Association of Operating Room Nurses, 16th annual meeting, Cincinnati, Ohio.

March 3-28, 1969
Advanced program in health services organization and administration, School of Hygiene, University of Toronto. Part two of course to be held in March 1970. For additional information and registration data write: Dr. R.D. Barron, Secretary, School of Hygiene, University of Toronto, Toronto 5.

March 10-12, 1969
15th annual combined meeting for doctors and nurses sponsored by the American College of Surgeons, Boston, Massachusetts. Further information is available from ACS, 55 East Erie St., Chicago, Illinois 60611.

March 18-20, 1969
Institute on Administration for Hospital Administrators and Directors of Nursing Service, conducted by Amer-

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ican Hospital Association. To be held at the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611. Apply to above address.

March 24-29, 1969
Symposium on recovery room and intensive care nursing, Grace General Hospital, Winnipeg. Registration: $20. For further details: Miss J.W. Robertson, Director - Inservice Education, Grace General Hospital, 300 Booth Dr., Winnipeg 12.

April 13-17, 1969
American Association of Neurosurgical Nurses Meeting, Cleveland, Ohio. Information may be obtained from: Miss S.M. Sawchyn, 99 Fidler Ave., St. James 12, Manitoba.

May 13-16, 1969
Alberta Association of Registered Nurses, annual convention, Macdonald Hotel, Edmonton, Alberta.

April 14 - May 9, 1969
May 12 - June 6, 1969
Rehabilitation Nursing Workshops, University of Toronto. Four-week course for R.N.s employed in acute general and chronic illness hospitals, nursing homes, public health agencies, and schools of nursing. Tuition fee: $150. Apply to: Division of University Extension, Business and Professional Courses, 84 Queen's Park, Toronto 5, Ont.

May 19-23, 1969
National League for Nursing, 1969 convention. To be held in Cobo Hall, Detroit, Michigan. Fee: NLN members, $15; non-members, $25. Write to: NLN, 10 Columbus Circle, New York, N.Y. 10019.

May 21-23, 1969
Registered Nurses' Association of British Columbia, annual meeting, Bayshore Inn, Vancouver. Write: RNABC, 2130 W. 12th Ave., Vancouver 9.

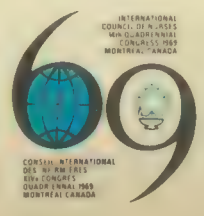
May 21-23, 1969
Canadian Hospital Association, 2nd national convention, Civic Centre, Ottawa.

May 28-30, 1969
The New Brunswick Association of Registered Nurses, annual meeting, New Brunswick Hotel, Moncton.

June 1-13, 1969
Eighth annual residential summer course on alcohol and problems of addiction, Trent University, Peterborough, Ont. Co-sponsored by Trent University and the Addiction Research Foundation, an agency of the province of Ontario.

June 16-18, 1969
Conference on nursing education for visitors to the International Council of Nurses Quadrennial Congress. Sponsored by the school of nursing and alumni association, University of Toronto. June 19-20: tours in Toronto and environs to be arranged at request of persons attending conference. Apply to the Secretary of the School, University of Toronto School of Nursing, 50 St. George St., Toronto 5.

June 22-28, 1969



International Council of Nurses' Quadrennial Congress, Montreal. Fee: before Jan. 22, $40; after Jan. 22, $60. Write to: ICN Congress Registration, 50 The Driveway, Ottawa 4, Ont. □







Second Conference

Hospital — Medical Staff Relations
16 to 19 February, 1969
Chateau Frontenac, Quebec City

Jointly Sponsored by:
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Canadian Nurses' Association
Canadian Medical Association

PROGRAM

Participants are divided into four sections, each including: Trustees; Administrators; Medical Staff Representatives; Nursing Representatives. Each section is further divided into two types of groups: A — professional; B — mixed.

Sunday, 16 February
Registration
Meeting of Group Leaders
Group Orientation — sectional
Reception

Monday, 17 February
Registration
Opening Ceremonies
Keynote Speaker: Dr. E. W. Barootes, Regina, Sask., CMA Executive Committee member
Meetings — sectional, A and B

Tuesday, 18 February
Meetings — sectional, A and B
Reception
Official Dinner

Wednesday, 19 February
Keynote Speaker: Dr. A. B. C. Powell, Medical Director, Workmen's Compensation Board of Ontario — "the Team Approach in the Hospital"
Reports of Sections
Summation

Topics for discussion include:
- purpose of the organization
- process of delegation
- creating opportunities to participate in decision-making
- process of communications.

new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.



Hotchkiss Otoscope

The Hotchkiss Otoscope is a new otoscopic system with coaxial lighting (the same principle as the headmirror), designed to improve and simplify ear examinations and instrumentation.

Designed by Dr. John E. Hotchkiss, a San Francisco otolaryngologist, the new system eliminates parallax error – a basic deficiency of standard otoscopic systems. It also provides up to four times brighter illumination than traditional otoscopes.

The optical head weighs only 2-1/4 ounces and measures 4-3/4 inches from the eye piece to the speculum tip. The instrument is designed to be held by the thumb and index finger of one hand leaving the mid-finger to straighten the canal and the other hand free for instrumentation, positioning the patient's head for pneumoscopy. An improved speculum design permits instrumentation under full magnification and eases the pneumatic procedure.

Other features of the instrument include an around-the-neck power supply, a 5x magnification unit, corrective lens for bifocal wearers, and completely disposable specula. In addition, by use of a photographic adaptor and single-lens reflex camera, the otoscope can be used for photography of the ear drum and nasal passages.

Additional information may be obtained from Smith Kline & French, Inter-American Corporation, 300 Laurentian Blvd., Montreal 379.

New Canadian Allergy Service

Winley-Morris Co. Ltd., in conjunction with Purex Laboratories Inc., New York, announces the establishment of a new Canadian Allergy Service under the Purex label.

Available from Montreal stocks are testing kits, treatment solutions, and accessories for a complete allergy practice.

Prices and catalogues are available on request from Winley-Morris Ltd., 2795 Bates Rd., Montreal 251.

Bedside Toilet

This electrically operated, recirculating flush toilet may be wheeled to the patient's bed. The Mobile Monomatic toilet eliminates patient stress and the psychological block often associated with bedpans and commodes. The toilet also substantially reduces nursing involvement with toilet duty and provides approved sanitation for areas that lack plumbing facilities, without costs of plumbing rehabilitation.

Because of the unit's proprietary chemical, the toilet provides immediate bacteria and odor control and results in less annoyance to other patients in the area.

For further information: Gerry Stevens Companies, 145 Wellington St., Toronto 1, Ont.





Child-Resistant Pill Bottle

This new child-resistant pill bottle, designed to prevent many of the accidental poisonings that occur every year, is marketed under the name "Palm-N-Turn." The new container consists of a polypropylene cap on a crystal polystyrene vial. To open the container, you must press the cap into the palm of the hand and give the vial a quarter turn to the left.

The pliable plastic cap has notches in it that fit over the lugs on the vial when the container is closed. You can pry it, twist it, or shake it, but it won't come off. By pressing it into the palm of your hand, however, a springy plastic disc inside the cap is depressed to release the notches from the lugs. A quarter turn then releases the cap completely.

Even if a youngster learns the knack, he's unlikely to be able to use it because it takes about 12 pounds of pressure to depress the plastic spring. While this is very little effort for an adult, it is about three pounds more than a typical five-year-old can bring to bear.

It is manufactured by Reflex Corporation, Amhurstburg, Ont.

Allergy Chart

To help mothers avoid allergens more completely, Gerber Products Company

new products

(Continued from page 27)

has prepared a chart listing the many Strained and Junior foods available for babies and indicating which, if any, of the four common allergens each food contains. Most food allergies among infants are caused by one of four common foods: milk, wheat, egg, and citrus fruit. Spotting the offender is usually fairly simple, and avoiding that food in its pure form is equally simple. These four foods, however, are also found as ingredients in many combination foods.

With the chart handy, a mother can determine at a glance whether a particular food contains the food element to which her baby is allergic. The chart is coded with the letters M (Milk), W (Wheat), E (Egg) and C (Citrus Fruit), and also contains a listing of all gluten-free Gerber Baby Foods.

Reprints of the chart are available from doctors or free on request from Gerber Products Company, Niagara Falls, Ontario.



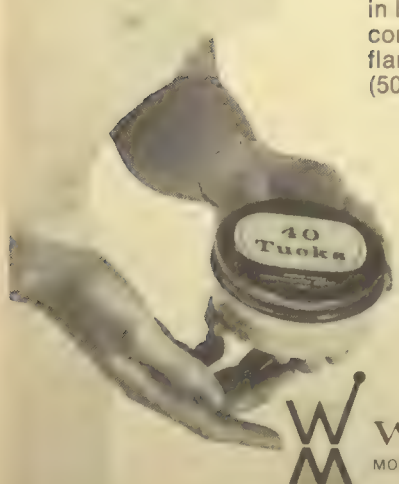
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Surgical Drain

This versatile new surgical drain features a triple-lumen construction that permits the drain to serve as an overflow, suction, and sump drain, depending upon the individual surgical requirement.

It will be known as the Abramson Drain, named after its inventor, Daniel J. Abramson, M.D., F.A.C.S., of the Washington Hospital Center, Washington, D.C.

The triple-lumen drain is elliptical with a large central lumen of approximately 1/4-inch I.D., and two companion tubes molded into the outer margins of the ellipse. The center lumen can be used for overflow, suction, drainage, or irrigation, or both tubes may be used for the same function.

Therefore, depending upon how the three lumens are used, the Abramson drain fulfills many functions.

The prospect of clogging is reported by Davol to be minimized by the triple lumen design and the large eyes on the distal tip.

Indications for use of this drain are: clean surgical wounds in which excessive drainage or bleeding may occur, such as operations on the biliary tract, thyroid, or breast; potentially infected wounds such as occur in trauma or emergency intestinal resections; established infections, as in peritoneal, pelvic, sub-hepatic or other abscesses.

Made of soft, pliable, medical grade PVC, the Abramson Drain is available in surgically sterile, 18-inch lengths.

Evaluation quantities are available to hospitals from Davol Inc., Providence, Rhode Island.



642 Tablets

642 tablets (propoxyphene HCl 65 mg.) are indicated for the relief of moderate pain. They are of value in providing symptomatic relief for: muscle and joint pain, premenstrual and postpartum pain, dysmenorrhea, pain associated with infection, postoperative pain, headaches, and post traumatic pain.

Orally administered, propoxyphene hydrochloride produces effective plasma levels within one hour, as evidenced by plasma experience. Less than 10 percent of the unchanged drug can be recovered

new products

from urine collected over a 24-hour period.

642 tablets are round, yellow, and film-coated, and are available in bottles of 100 and 500 tablets. Full information may be obtained from: Charles E. Frosst & Co., P.O. Box 247, Montreal 3.



Cytec

Cytec is a modern method of sputum analysis for the detection of lung cancer in its most curable and easy-to-treat stages.

The Cytec system consists of an electronic computerized cyto-screening analyzer that can measure cell parameters and distinguish the difference between normal and abnormal cells, and a kit for the collection of early morning cough specimens.

Modern bio-engineering techniques now permit optical scanning of free floating sputum cells at the rate of 200 per second for approximately 20,000 cells from a four-day specimen, as compared with only a few hundred cells possible by conventional methods.

Significantly, these same optical scanning techniques permit accurate detection of the early biochemical changes in nucleus and cytoplasm known to occur in the premalignant cell, some 36 months prior to any radiological evidence.

If used in mass screening of an entire population, the Cytec test can lead to significant reduction of the mortality rate in this disease.

Senokot Syrup

This pleasant tasting syrup is indicated for the effective correction of constipation. Each 5 ml. contains the equivalent of 2 ml. of Standardized Senna Syrup Concentrate standardized to an average value of 5 mg. Sennosides A and B per ml.

Senokot Syrup is particularly acceptable to children and the elderly. It offers the advantage of teaspoon, not tablespoon dosage.

Further information is available from The Purdue Frederick Company (Canada) Ltd., 123 Sunrise Avenue, Toronto 16, Ont.

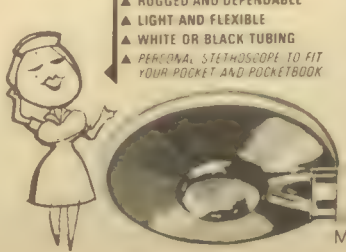
Valium Injectable

After four years of clinical investigations by over 200 Canadian physicians, Hoffman-LaRoche Limited, Montreal, has released an injectable form of Valium, one of the most widely prescribed psychotropic drugs. Valium Injectable is especially useful when rapid onset of action is required in acute anxiety or tension states related to stressful conditions.

Each 2 cc. Valium ampoule contains 10 mg. diazepam. It is indicated for the relief of anxiety states including those present before minor surgery and prior to esophagoscopy and gastroscopy; relief of muscle spasm in cerebral palsy and athetosis; and control of prolonged seizure activity in status epilepticus.

For further information: Hoffmann-La Roche Limited, Montreal 9. □

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Canadian quirks

Who says you can't tell a Maritimer from a British Columbian? Or an Ontarian from a Newfoundlander? Or that *les Québécois* have succumbed to English-Canadian habits? According to *Marketing* magazine, advertisers have dollars-and-cents evidence that we're all individual – in our eating habits at least.

Take potato chips, for instance. Quebeckers consume by far the most potato chips of any of their compatriots in the other nine provinces. Torontonians, however, are more economy minded when they buy potato chips; 59-cent-and-up bags capture 75 percent of the Toronto market. In the less affluent Maritimes, however, five-and ten-cent bags corner the market.

Easterners appear to like their coffee quick and easy whereas Westerners prefer to wait awhile to savor theirs. Much more instant coffee is sold in the eastern provinces; Westerners not only prefer the ground variety, but drink it much stronger than do Easterners.

Quebec, though, has the most individual eating habits of all 10 provinces. Manufacturers claim that in other parts of Canada they couldn't give away the spruce beer that is a bestseller in Quebec. Quebec also is the largest per capita soft drink market in the world. And Quebeckers don't restrict their buying to spruce beer, ginger ale, or colas; they drink everything from cream soda to lemon-lime.

Les Québécois consume 80 times as much molasses as other Canadians. They eat two olives to an Ontarian's one. They buy more expensive cuts of meat than their richer Ontario neighbors. They turn up their noses at the quick dinners in a can – such as chili con carne and weiners and beans – that other Canadian housewives couldn't do without. And despite their larger families, they prefer their fruit juices in 20-ounce to 48-ounce tins.

The key to success on the Quebec market, according to one food marketer quoted in *Marketing,* is "make it sweet, make it red and make it chocolate. And you've got it made."

In any case, there's no such thing as a national food market in Canada. "It's a whole lot of smaller markets, each one with its own peculiarities in different product categories," says a food marketing expert.

You couldn't look that one up in your *Funk and Wagnalls.*

Beautiful nurses

Nurses are renowned for their beauty all over the world and Canadian nurses are no exception. It was Canadian nurses, after all, who established the image of Air Canada's gorgeous hostesses. You may recall as well that last year's Miss Canada was a student nurse. And now, a Canadian nurse has been chosen by Breck Inc. to be a "Breck girl."

You're probably familiar with the head-and-shoulder pastel portraits that appear in popular magazines to advertise Breck shampoos. At a recent symposium of operating room supervisors held in Niagara Falls, representatives from John H. Breck, Inc. chose blonde Virginia Gardhouse, an operating room supervisor at Queensway Memorial Hospital in Etobicoke, Ontario to pose as a Breck girl.

Miss Gardhouse will receive a pastel portrait of herself and have the added thrill of seeing her portrait in magazines all over North America.

Cold type

Did you wonder whether you needed new glasses after reading last month's THE CANADIAN NURSE? Our printer is using a new kind of type, called cold type, which is set by an IBM machine. The January issue was the trial run for this type and there were a few problems.

For one thing, the type was rather small. We hope that the larger type you are now reading will be easier on the eyes. Another slipup was in the bold type headings, some of which were misprinted. For instance, did you notice the "new desing" featured in the Idea Exchange?

We hope that these wrongs have been righted in this issue.

Back to nature

From time to time we receive unusual requests for use of space in this magazine but the most unusual of all was surely this: a "naturist-nudist" camp wishing to advertise in THE CANADIAN NURSE and run "one and many repeats."

Nurses would be naturals for membership in this camp, the management believed, because they have such a lot of responsibility and are on their feet day and night. They could find "real relaxation in our camp." A bonus for nurse members would be building up their body resistance against many possibilities of infections.

We never did receive the actual copy for this advertisement, but we must admit that we were curious about what aspects of life in the camp it might illustrate! □



Time is flying the ICN Congress is coming up in June.

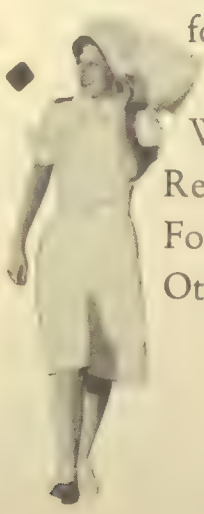
We want a nurse who can handle two jobs: one who can nurse the men of the Canadian Armed Forces and who can accept the responsibilities of being a commissioned officer. That's why we're offering a salary of more than $590.00 a month. It's interesting work. You could travel to bases all across Canada and be employed in one of several different hospitals.

It's challenging. You'll never find yourself in a dull routine. And, in addition, you have the extra prestige of being made a commissioned officer when you join us.

We want a special kind of nurse.

If the idea intrigues you, you're probably the kind of special person we're looking for. We'd like to have you with us.

Write: The Director of Recruiting, Canadian Forces Headquarters, Ottawa 4, Ontario.



GO WITH US! THE CANADIAN ARMED FORCES

when traumatic pain stops the action... stop the pain with PONSTAN®

(mefenamic acid, Parke-Davis)

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*In a controlled study of 920 patients with pain of varied etiology, including muscular aches, sprain, backache, dysmenorrhea, toothache, and bursitis, *relief of pain after only one dose of PONSTAN was reported as good to excellent in 85% of the patients.*

INDICATIONS: Relief of pain in acute and chronic conditions ordinarily not requiring the use of narcotics.

DOSAGE AND ADMINISTRATION: Adults and adolescents over 14 years of age—500 mg. (2 capsules) as an initial dose, followed by 250 mg. (1 capsule) every six hours as needed. The major portion of clinical experience with PONSTAN has varied from single doses to 84 days of therapy.

CONTRAINDICATIONS: Intestinal ulceration; diarrhea as a result of taking the drug; safe use in pregnancy not established; in children under 14 years of age until pediatric dose has been established.

PRECAUTIONS: Administer with caution to patients with abnormal renal function, inflammatory diseases of the gastrointestinal tract, or those on anticoagulant therapy. Discontinue if diarrhea or rash occurs.

SIDE EFFECTS: Mild and infrequent at doses up to 1500 mg. per day; dose-related, being more frequent with higher doses. Most frequently reported: drowsiness, dizziness, nervousness, nausea, diarrhea, G.I. discomfort, vomiting.

FOR DETAILED INFORMATION ON PRECAUTIONS AND SIDE EFFECTS SEE PRODUCT BROCHURE AVAILABLE ON REQUEST.

SUPPLY: Kapseals® of 250 mg. in bottles of 100 and 500.

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Epidermolysis bullosa

The story of two children who, with considerable care and support, have learned to cope with a rare, chronic, hereditary skin disease.

Emily Melnyk

The skin you are born with is yours for life – however long that may be. It is more than a protective covering – it is an organ ranking in importance with the brain, the heart, and the lungs. Your skin, because it is with you from the beginning, is peculiarly your own, even more than your personality. No other person's is quite like it. An example of this uniqueness is your fingerprint pattern that never duplicates that of anyone else.

But nature can play tricks with the packaging of our bodies, as the histories of the following two children with a rare disease called "epidermolysis bullosa" show. When Christ said, "Suffer little children to come unto me," He must surely have had in mind little ones such as Stephen and Marie, for their climb along life's highway is indeed frightening and hazardous.

"Are these burn cases? " ask student nurses and visitors to Bloorview Childrens Hospital after seeing two of our patients, Marie and Stephen.

On hearing the medical terminology for the condition "epidermolysis bullosa," most people remark that this is a mouthful; after an explanation of the treatment and nursing care involved, all comment that this is also a handful!

Epidermolysis bullosa is an uncommon, chronic, hereditary disease of the skin, exhibiting several clinical forms and characterized by the development of sub-epidermal bullae following slight friction or trauma. These bullae contain a fluid that is usually serous but quite often hemorrhagic or purulent. They tend to enlarge with pressure and eventually break down into painful, shallow denudations which, on healing, leave scars.

First observed by Dr. Von Hebra in 1870 and described by Dr. T. Fox in 1879, epidermolysis bullosa received its present name from Dr. Koebner in 1886. In most countries, the name commonly used for this condition is chronic pemphigus.

Currently, it is classified into four basic types:

1. *Simplex:* This type accounts for 45 percent of all cases. It is self-limiting, non-scarring and inherited by Mendelian dominant trait. Bullae, containing clear fluid, appear on the hands and feet. They generally heal without scarring and tend to decrease in severity as a patient grows older. There may be transitory pigmentation associated with the healing. The mucosal epithelium is rarely involved. Patients have a normal span of life.

2. *Hyperplastic Dystrophic:* Approximately 30 percent of patients with chronic pemphigus fall within this classification. It is transmitted by a single autosomal recessive gene. Onset may occur at any time from birth to maturity. The mucosal epithelium is involved in about 20 percent of the cases. Bullae result from minor trauma to the skin, and contain either clear or hemorrhagic fluid. Healing is accompanied by scarring. White papules, one to two mm. in diameter, frequently appear due to involvement of the sebaceous ducts.

3. *Hypoplastic Dystrophic:* This classification accounts for 25 percent of all cases and is also transmitted by a single, autosomal recessive gene. According to well-known dermatologists, there are six patients in Canada with this type. The onset is at birth; the newborn baby's skin may have a few sub-epidermal bullae at the time of delivery. These increase in size during the first few days of life. Widespread bullae develop following very minor trauma, and affect both skin and mucosa. They heal with extensive scarring. The skin becomes thick and xerodermic in appearance; nails are deformed or absent; teeth are hypoplastic with extensive early cavities. The eyes, respiratory tract, esophagus, anus, and vagina may be affected. Contractures, disappearance of the distal portions of digits, and total encasement of the hands in scar tissue have been known to follow.

In severe cases, dwarfism (cachexia) is manifested. Marie is a good example of this aspect. In the past, many in this category died before reaching maturity. However, because of lack of research evidence it is hard to determine (due to the rarity of the disease, the short lives of those afflicted, and thus the lack of opportunity for extensive research) if this were due to the primary condition or to secondary infection and loss of blood. New concepts of treatment involving the use of steroids, and advances in plastic surgery promise a better prognosis for the

Mrs. Melnyk, a graduate of University School of Nursing, Graz, Austria, is Assistant Director of Nursing Education at the Bloorview Childrens Hospital in Toronto. She expresses her appreciation to Dr. Otto Weininger, psychologist, and the nursing staff at Bloorview Childrens Hospital, for their help in preparing this article.



Marie, aged 14, was admitted to Bloorview Childrens Hospital in Toronto with epidermolysis bullosa when she was two years and three months old.

future.

Both Stephen and Marie have all the characteristics described in this type of epidermolysis bullosa. The intelligence quotient of both our little patients (75 to 80 – low average) is a coincidence. It is not one of the characteristics of the condition.

4. *Letalis:* This type is very rare. Infants die after a few weeks.

Etiology

Epidermolysis bullosa is caused by a genetic defect and represents some type of biochemical imbalance, presently unknown. The epidermis is frequently separated from the corium of the skin and in the dystrophic type involving mucosal epithelium it separates from the underlying tunica propria. Researchers have hypothesized that the underlying cause is a vascular defect, deficient elastic tissue, or dysfunction of the hyaluronidase hyaluronic acid system.

During the early 1950's, patients were treated in various ways. In 1952, Dr. Langhof used an ointment containing heparin to prevent blistering. Deficiency of heparin was considered responsible for imperfect hyaluronidase metabolism. In 1957 Dr. Dorn treated two families with heparin and ephedrine hydrochloride. In that same period early reports concerning ACTH treatment were disappointing.

At the present time, the beneficial results achieved with corticosteroids are thought to be due to two independent effects: 1. control of the inflammatory process and reduction in tissue damaged; and 2. restoration of the normal adhesive mechanism of the epidermal cells and prevention of blood loss.

In March 1967, G.L. Severin described the management of epidermolysis bullosa in children with topical application of steroids – 0.2 percent fluocinolone acetonide cream.

Treatment

These little patients need an intensive program of regular supportive care. The objectives are:

- To prevent bullae formation.
- To prevent the spread of established bullae.
- To prevent secondary infection and expedite healing.
- To prevent contractures.

The following measures are helpful in attempting to attain these objectives:

- Bedding should be of soft, smooth materials. Infrequent handling of the patient as well as careful feeding are advisable. For instance, hot, pureed food should not be given. Physical stress and trauma must also be avoided.
- Incision of bullae, or careful removal of four to six mm. of tissue, is performed to decompress tense lesions and prevent spread of infection.
- Bathing with an antibacterial cleansing agent and application of antibiotic ointment help to protect the denuded areas.
- Passive range of motion exercises, as tolerated, are beneficial.

At Bloorview Childrens Hospital, only the supportive type of treatment is used at present. With advanced techniques in plastic surgery, surgical reconstruction of the hands may be anticipated in the future.

Stephen

Stephen, aged 9 years and five months, has been a patient at Bloorview Childrens Hospital for just over two years. He is an only child. A report from the Ontario Society for Crippled Children's district nurse states, "Stephen's mother seems to have had an excellent understanding of the child's illness and her attitude toward his disability is very understanding. When Stephen was at home she did his dressings several times daily, and was able to carry out the doctor's orders."

Stephen's treatment and medications, as will be seen from the following outline, are intended to promote general physical well-being to the greatest extent possible, and to protect his fragile body from the added burden of superimposed infection.

Chlor-triplon Syrup 1 tsp. t.i.d. with each meal
Winstrol 2 mg. b.i.d.
Orbenin 125 mg. q.6 h.
Prednisone 5 mg. t.i.d.
Poly-vi-sol 0.6 cc. o.d.
Nupercainal ung. to relieve pain from lesions



"One more dressing and I am ready to hug you," Marie said after her daily dressing.



In epidermolysis bullosa, bullae develop following minor trauma and affect both skin and mucosa. They heal with extensive scarring.

Neosporin ear and eye drops q.i.d.
Metamucil h.s. or mineral oil, occasionally
3 percent hydrogen peroxide diluted to
1/2 strength and used t.i.d. as mouth wash
Fer-in-sol 1 cc. t.i.d.
Dressings of Triburon Creme once a day,
or as necessary
High protein diet using baby foods
Weekly urinalysis
Hemoglobin estimation as necessary
Alpha-Keri in bath

Stephen starts his day at 7:00 a.m. While still in bed, he begins to remove his dressings – this usually takes him about half an hour. He prefers to do this by himself because, as he explained, he is afraid of the pain that might occur should a staff member remove a dressing too suddenly. Every second day he has a warm tub bath to which has been added Alpha-Keri oil and Phisohex. Usually he stays in his bath for at least 20 minutes, enjoying it while his hair is washed with Nivea Creme shampoo. During the shampoo, his head is held in a backward position to prevent soap from getting into his eyes.

Unfortunately, even though he enjoys his bath, he cannot be bathed daily because his lesions become jelly-like and do not dry as quickly. His dressings, however, are changed at least once a day or more often, if necessary.

After his bath, Stephen is lifted out of the tub to the dressing table, a piece of Saran Wrap is placed beneath his buttocks, and he is left to dry for a few minutes.

Stephen's nurse makes sure that the supplies she needs to complete his care are on the dressing trolley. This includes two stainless steel pans, 6" x 4", containing autoclaved squares of soft tulle gauze covered with Petroleum Jelly. Another small container, filled with alcohol, holds lifting forceps and scissors. Triburon Creme, spatulas, and other treatment materials are also available. Sterile technique is not necessary, but surgical cleanliness and loving patience on the part of the nurses who care for Stephen are required.

The soft tulle gauze is lifted with the forceps and placed on a clean working surface. A minimum amount of Triburon Creme is applied with a spatula and the gauze is then applied to the area. This is repeated until all denuded areas and blisters have been covered.

Stephen's arms are dressed first and then a tubular stockinette sleeve is pulled on gently to hold the gauze in place. A specially-made flannel vest joins at the shoulders with the arm stockinette, and effectively secures the dressings on his back and chest.

His legs are dressed in the same manner as his arms. However, part of the stockinette covering his foot is doubled over to form a sock. Stephen wears a minimum amount of clothing. Small pieces of perforated Saran Wrap are put over his elbows and knees when he attends school to protect his books and school materials from becoming oily.

Stephen is handled as little as possible throughout this part of his care. Other than lying down once for his leg dressings, he sits up for the entire procedure.

When his dressings are completed, Stephen receives his nose and eye drops. Mouth care is given after each meal and at bedtime.

Physiotherapy for this little boy consists of breathing exercises and gentle passive movement of his extremities to prevent contractures. Occupational therapists teach him how to perform various activities of daily living, for example dressing himself – he is now able to put on his own shirt – and encourage him to be as independent as possible. He is also learning to type, using his four unaffected fingers and his wrists.

Stephen is co-editor of Bloorview's *Morning Glory,* a newspaper containing articles about the hospital written by the children. He has a keen sense of humor and is the source of most of the funny tales that are published.

Stephen is very active, pushing himself around in his wheelchair and in general maintaining a very independent attitude. Since his physical condition does not permit him to reach for objects or to push buttons for elevators, he uses a specially-designed small rod that he carries about constantly. This permits him to overcome some of his limitations in school.

He is progressing moderately well in school. His teacher says that he "works very conscientiously" and that he "has completed all of his work with very good results." He has successfully met the requirements for grade three work in reading, spelling, and arithmetic and is now progressing into grade four. Stephen enjoys school and its many challenges.

Two weeks after his admission to Bloorview, Stephen was seen by a phychologist. The results of tests carried out then indicated that he was functioning within the low average intellectual range. There has been no significant change in this level.

According to the psychologist's assessment, Stephen is constantly striving to maintain control over feelings of hostility or aggression: "The particular way in which he seems to maintain this control is by trying to figure out what exists within the particular situation that is either threatening or potentially harmful to him." Thus, when confronted with specific situations, Stephen views them as threatening to himself and tends to react to each one in similar, if not identical, ways.

The particular kind of harm that he is most concerned with at this point is physical danger that might exacerbate his skin condition. He even feels that any expression of anger on his part is potentially damaging to his skin, since it might excite others to become angry with him and to harm him physically. Certainly there are times when he feels angry, but he controls any expression of this fairly well. Stephen also tries to deal with other small aspects of his existence through meticulous attention to minute detail. This serves to suppress impulsive action and hostility.

According to the psychologist, "The general emotional patterning is one where feelings and impulses to aggression are strong, but are most unacceptable and their direct expression is severely repressed." Stephen's reaction is seen as internalized aggression with a proneness to indiscriminate perception of and response to frustration with passive feelings, denial of aggression, and overly amenable, socially nice behavior.

He tries hard to be pleasant and to have a smiling face at all times. As a result, it becomes extremely difficult to

have him talk freely about his real feelings. The Projective Psychological Tests indicated that his anxiety level is high and that most situations present difficulties for him. This anxiety must be seen in relationship to Stephen's inability to cope with the external world, through fear that it will harm him. In a way, he is being realistic, but since he does not really test his world to find out what its advantages or disadvantages are, he remains in a kind of cocoon whereby real feelings are denied or inhibited by rigid intellectual processes or by complusive attention to small detail.

Stephen's reaction to mental stress is poor. He has little emotional energy with which to respond to stressful situations. His usual response is to withdraw, feeling that he has done something wrong. This pattern of feeling angry with himself becomes most marked when he is under any kind of real emotional stress.

There has been marked improvement in his relationships with other children – he is learning to share toys, records and books. He has a few favorites among the nursing staff to whom he tells a few of his "secrets."

Marie

And now let us meet Marie, aged 14, who has really never known any other home than Bloorview Childrens Hospital. She was admitted when she was only two years and 3 months old.

Marie is small for her age. Physically, she resembles a child of approximately 6 years. However, she refuses to be unduly limited either by her size or her physical illness. She pushes herself around in her wheelchair; she feeds herself; she writes, using protective coverings for her hands.

Her medications and treatment are very similar to Stephen's:

Meticortone 2.5 mg. t.i.d.
Lederplex liquid 1/2 tsp. t.i.d.
Fer-in-sol 1.2 cc. t.i.d.
Poly-vi-sol 0.6 cc. o.d.
Metamucil h.s. – mineral oil occasionally
Petroleum Jelly dressings to body o.d.
Alpha-Keri oil and mild soap for bath
Cortef ung. to open lesions
Soft or pureed diet – she is unable to chew or masticate food well
High protein, carbohydrate, and fat diet
Weekly urinalysis
Frequent hemoglobin estimations

Marie's dressing procedure is similar to Stephen's except that Petroleum Jelly is used instead of Triburon Creme. Her physiotherapy consists of gently passive extension of wrists, elbows, and knees, and active exercise of joints and shoulders three times weekly. She attends cooking class as part of her occupational therapy program. Her favorite pastimes are coloring and painting, which she does rather well, holding a pencil or brush between the backs of her bandaged hands. Each drawing usually occupies a full page, is very colorful, and full of small details. She often has a central figure doing things for younger children – caring for them – and as a rule the "younger" children in her drawings are using aggressive words, such as "no," or "no, I don't."

Because of the severity of her physical disability and her need for considerable medical treatment, Marie has attended school irregularly. As a result she has advanced only to the grade 4-5 level, and in fact some of her work is still at the grade 3 level. She is presently reading at the grade four level; her spelling is within the grade five level, but her mathematical ability is only within the grade three range. Her teachers are encouraging, however. They note that she is a "hard worker, enjoying class activities."

Intellectually, Marie has the capacity for further academic achievement. Children of her intellect usually can achieve grade eight standing. Since she is interested in continuing her education, she will no doubt complete this level.

Marie, too, underwent psychological testing. The first such examination was carried out when she was just two months of age. Her general level of intellectual functioning was found to be within the lower range of the dull normal grouping (I.Q. 80-90).

Just prior to her admission to hospital, she was again tested. While her level of intellectual functioning remained essentially the same, she appeared to have the potential to function within the low average range. It is possible that the hospital environment failed to provide her with sufficient stimulation on a consistent basis to enable her to function on the higher level.

Marie's emotional development presents another aspect that must be considered in relation to her physical illness, and not just as the end result of an impoverished institutional life in terms of human affection. There are times when she is upset and angry, with subsequent physical distress, but she is unable to verbalize her feelings or to "act them out" in aggressive behavior. She considers "good" behavior in terms of provision of physical care. An expression of anger is "bad" since it may mean the withholding of the care that she needs.

"Physical care increase" satisfies another of her strong needs. Her passive dependency needs – the need to rely upon, to be cared for, to be given psychological support – come into the open especially at times of emotional stress. Marie likes to be the center of attention.

Her lack of family relationships is compensated for by a close relationship with a mature nurse – a member of a religious order – who is extremely interested in Marie and able to give her the necessary psychological support. She visits Marie regularly, is always available by telephone, and has become a mother figure for the little girl.

Although bodily contacts are frequently painful, Marie likes her friends to pat her occasionally, and appreciates the close contact that she has with the nurses during her early morning treatments. "One more dressing and I am ready to hug you," was the remark overheard one morning as Marie and her nurse finished off that part of her daily routine.

Conclusion

You have read about two children whose hopes for the world of tomorrow may remain unfulfilled. The songs that they can sing are perhaps less sweet than those they had dreamed of singing. Their wishes are no less noble because they may never be realized.

With knowledge, experience, and physical help, we can make little lives such as these not just more tolerable but as happy as possible. As nurses we must think positively when caring for such children. We must be like the miner who remarked that he had hunted for gold for 25 years. He was asked how much he had found. "None," he replied, "but the prospects are good! "

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Hyperbaric oxygen units — high pressure nursing

A hyperbaric oxygen unit offers a new kind of high pressure challenge for a nurse. She has to handle emergency treatments, surgery, bedside care, reassurance, and teaching — all carried out in a tiny submarine-like chamber that simulates treatment at undersea pressures.

Glennis Zilm

One day last year a young Ontario man caught his hands in a farm reaping machine. The wounds were large, open, and deep; as well as the severity of the wounds, an immediate danger was a gross fulminating gas gangrene infection that became apparent right from the time he arrived at the local hospital.

After preliminary emergency treatment – suturing and bandaging of the wounds – he was transferred immediately to the Toronto General Hospital. By that time, crepitus – the most dread symptom of the anaerobic infection – could be heard in the shoulders and chest walls. His blood pressure (taken on the leg) was low, pulse was 180, respirations 40-50, and temperature 105 degrees.

With only the classical methods of treatment – antibiotics, serum, and surgery – this young man would have died. He lived and recovered because the Toronto General Hospital has a hyperbaric treatment unit.

Hyperbaric oxygen is rapidly gaining value as a treatment method in various parts of the world. Although techniques of subjecting a patient to increased atmospheric pressure were used as early as 1662 and were in vogue in the 1800's, only within the last decade have the therapeutic possibilities been clinically researched.

Major investigation into modern uses of hyperbaric oxygen therapy was first begun in Amsterdam, Holland, in 1956. Since that time units have been set up in many parts of the world. The Royal Victoria Hospital in Montreal established the first Canadian medical hyperbaric oxygen chamber in October, 1963. Toronto General Hospital opened its unit in 1964, and The Vancouver General Hospital opened a unit in 1965.

Much background information on hyperbaric treatment developed from the techniques evolved to enable man to build or repair structures under water. Atmospheric pressures had to be raised inside diving bells or caissons to correspond to the increased water pressures outside, and modern medical research relies on knowledge of decompression sickness, nitrogen narcosis, and other physiological and psychological changes documented by deep-sea diving teams.

Uses

The use of hyperbaric oxygen implies that the patient is breathing in an atmosphere in which the pressure is greater than atmospheric pressure (at sea level), and in which he is provided with an increased intake of oxygen (usually by mask). As a result, oxygenation at the cellular level is improved.

In normal atmospheric conditions and breathing air, a person will show a partial pressure of oxygen in arterial blood pO_2 of approximately 100 mm. Hg. Under normal atmospheric conditions but breathing pure oxygen, the subject can raise his arterial pO_2 to 500-600 mm. Hg. At three atmospheres pressure, the subject will show an arterial pO_2 increased to 1500-1800 mm. Hg. The amount of oxygen dissolved into plasma is directly related to the pO_2 so in hyperbaric conditions the amount of oxygen available to body fluids and tissues is greatly increased.

This increase of oxygen at the cellular level is useful in treating conditions such as infections where lack of oxygen plays a part (gas gangrene), carbon monoxide poisoning, decompression sickness (bends), ischemic diseases (threatened gangrene, frostbite), and, in some instances, shock.

It may also help in some respiratory or cardiac diseases, selected cardiovascular accidents, plastic surgery, and vascular occlusion where a temporary ischemic state may be reversed by medical or surgical treatment.

Hyperbaric oxygenation also appears to be effective as an adjunct to radiation therapy and to some of the newer drug therapies in the treatment of malignant tumors. The theory behind the use of hyperbaric oxygen treatment in malignancies is based on recent discoveries that tumor cells, because of the mass, are often anoxic and have poor blood supply. Normal cells, which have a good blood supply and less pressure, are not overly affected when subjected to hyperbaric oxygenation, but the oxygen supply to the tumor cells is increased, and the effect of the radiation or drug is enhanced at the cancer site.

Side Effects

Not all the effects of hyperbaric oxygenation are beneficial, although in normal therapeutic situations side effects are minimal. Two main types of side

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The members of the hyperbaric unit staff gather around to help lift the patient into the submarine-shaped chamber. A special carrier helps slide the stretcher over the sill of the port-hole type door.

effects occur: physiologic and/or mechanical.

An adverse effect of oxygen at increased pressure is oxygen toxicity or oxygen poisoning. Although little is known about the mechanism, lengthy exposure to high concentration of oxygen even at normal pressures leads to central nervous system disturbance. Warning signs – sudden apprehension, circumoral pallor, vertigo, nausea, choking sensation, tremor – lasting 20 to 30 seconds may precede generalized convulsion. If oxygen is terminated immediately and the patient allowed to breathe air, recovery is prompt and no adverse effects are noted.

Oxygen toxicity is extremely rare in therapeutic concentrations, such as two to three atmospheres for two hours or less. However, in attempts to find out more about the condition, investigations are being carried out with electroencephalograms (EEC) as a means of indentifying oxygen toxicity in its earliest stages.

As well as this physiologic oxygen toxicity effect, mechanical side effects are produced upon gases within the body. Under hyperbaric conditions, gas in body air spaces becomes compressed. Then, if a rapid decompression occurs, the expanding gas gets trapped in these spaces – or bubbles may even appear in blood or tissues – and this may cause serious pressure effects.

Decompression sickness, or "bends," is the name given to the symptoms occurring when a person has come up too rapidly from a depth. It is occasionally seen when deep-sea divers must be brought to the surface too quickly. The theory is that minute gas bubbles occur in the blood or tissue. In the early stages, it causes severe joint and muscle pains; later, it may even lead to death. The nitrogen component in normal air is the most likely to cause bubbles in blood or tissues as nitrogen is not metabolized by the body in any way; the specially controlled therapeutic atmosphere of pure oxygen is much less likely to cause gas bubbles in blood or tissues.

Body air spaces usually affected are the ear chambers, the gastrointestinal tract, sinuses, and the lungs. During pressure changes, air enters or leaves the middle ear cavity through the normally-closed eustachian tube, thus equalizing pressure on the tympanic membranes. Should the eustachian tube not open freely when the pressure is reduced following treatment, the eardrum may stretch as the trapped gas expands, causing pain or even perforation. Persons with conditions that contribute to blockage of the eustachian tubes – such as head colds or sinusitis – are usually not candidates for hyperbaric work. Patients who require therapy may require a myringotomy to prevent middle ear discomfort.

Gas in the gastrointestinal tract, caused by either swallowing air or by gas production while in the hyperbaric atmosphere, may lead to abdominal distention during decompression. Anxiety is a contributing factor because the anxious person is prone to both excessive air swallowing and increased gastrointestinal activity. Diets with a low intake of gas-producing foods may help.

Mechanical effects on the respiratory system have serious complications. Compressed gas trapped in a respiratory passage, such as through obstructions such as mucous plugs or breath holding because of fright, can cause rupture of alveoli, or even pneumothorax, interstitial emphysema, or air embolism during decompression. Special care must be taken with persons who have any symptoms of respiratory conditions.

Minor mechanical effects are experienced when gas is trapped in small air spaces, such as between the teeth, and causes pain on expansion; occasionally patients will complain of this.

Decompression sickness and the mechanical side effects of exposure to high pressures are avoided by gradual, staged decompression. Specific regulations on the amount of time required for decompression are controlled by an experienced operator outside the chamber.

The controllers – non-medical personnel who operate the pressure equipment of the chambers in Canada's three units – are all former Navy personnel who have spent most of their lives in this work. They are fully aware of the dangers of decompression, having experienced pressurization and decompression many times. When decompression is carried out gradually and the patient and personnel adequately prepared psychologically, the effects are minimal and not bothersome.

Taking a dive

The team needed for hyperbaric treatment includes a doctor and nurse

specially prepared in the method of treatment, and qualified controllers who regulate the pressure equipment for the chamber. Medical staff must be trained in the uses and effects of hyperbaric treatment, and they must be qualified "divers."

Vicki Kent, a graduate of The Vancouver General Hospital and charge nurse of the Hyperbaric Unit at the Toronto General Hospital, explained the orientation procedure for new nurses who come to work on that unit. A preliminary screening of applicants is carried on by the nursing department, and then the applicant reports to the Hyperbaric Unit. Mrs. Kent arranges for a physical check-up to ensure that the nurse is physically fit for exposure to hyperbaric pressures, to provide base line findings that would be available if any complaints developed after diving, and to provide control findings for research on the effects of repeated exposures to dives.

The physical screening procedures include a physical examination, ear-nose-throat examination, audiogram, vital capacity and pulmonary function tests, electrocardiogram, blood tests, urinalysis, electroencephalogram, eye examination, and full chest plate and x-ray of long bones. These are carried out by the various hospital departments, which are aware of the special interests of the hyperbaric oxygen department. Results are sent to the Unit.

After the nurse has passed her physical, she reports for a chamber pressure and oxygen tolerance test under the supervision of Mrs. Kent or one of the doctors assigned to the unit. The applicant and the examiner enter the chamber and "descend" to a pressure equivalent to 165 feet below sea level (six times atmospheric pressure). This is an unusually deep dive, and it is unlikely that the nurse will ever need to go to that depth again, but she learns what it is like, and she has a chance to determine her tolerance to pressure. Dives of 100-165 feet may be required to treat patients suffering from decompression sickness; therapy dives are usually only 33-66 feet.

Before and during the dive, the examiner explains what is going on and how to minimize side effects. Staff are taught the Valsalva manoeuver to equalize ear pressure (this involves a kind of yawn that stretches the openings to the eustachian tubes and permits the pressure in the middle ear to be equal to that in the outer ear).

After a few moments at 165 feet, the pair "come up" to 60 feet of pressure, and the applicant then takes 30 minutes on straight oxygen. During this period the examiner watches for any evidence of oxygen toxicity, and uses the time for discussion of equipment kept in the chamber, the type of conditions that are generally treated, and so on.

After the applicant has finished this part of the examination, she and the examiner "come to the surface." The applicant must stay on hand in the unit for at least 30 minutes, and this time is used for teaching – about pressure, emergencies, and about the life and death aspects of fire safety and pressure control.

The most serious worry for staff in the units is fire, and all staff must be extremely fire conscious. Chambers are made as safe as possible. All monitoring and electrical equipment is isolated outside the chamber and any equipment in the chamber has passed rigid safety codes. Any material or equipment taken into the chamber is screened by a fire-conscious controller. All clothing, bedding, wrappers, and such are made of fire-resistant cloth or have been treated to be fire resistant. No oils, lubricants, or other combustible materials are used. If anesthetics are to be used, they must be non-combustible, and this has created special challenges to the anesthetists in some instances. Anesthetic gases are avoided.

Safety features include fire blankets that are kept inside the chambers, an automatic sprinkler system, and individual face masks for every person in the chamber. If a fire should start, the oxygen flow shuts off, and compressed air is delivered through the masks.

As J.H. Wilson, chief controller of Toronto General's Unit explains, "If all fire rules are followed, then there really is no danger." Staff are constantly aware of just how much the rules really mean to them.

The applicant, if she has passed all the tests so far, then comes back to the unit for another dive – this time to learn a bit about the working of the pressure controls from inside the chamber. Although the nurses become quite knowledgeable about the pressure controls, they only practice at low pressures and only moving "down."



Several types of chambers are used for hyperbaric treatment. This small, patient-only tank is used quite extensively in Britain.

Treatment dives

Work in the three chambers in Canada involves about one-half the dives with patients for treatment; the other half of the dives are for research experiments. In all three centers, medical staff carry out experiments on animals to test the effects of hyperbaric oxygen exposures and to learn ways that it may be used more

effectively in the future.

Most of the treatment work at Toronto General is emergency work; the other two centers do more routine treatments, such as adjunct therapy for cancer treatments and routine treatment for plastic surgery.

The chamber in Toronto is too small for surgical procedures, although some experimental surgery is carried out on animals there.

In The Vancouver General Hospital's the largest in Canada, they have done some surgery, although it is very crowded. The chief controller, E.D. Thompson, has used his ingenuity to save any extra bit of space inside the chamber, and has even adapted French racing car headlights as operating lights as they are small, yet provide excellent illumination.

Emergency call

Although the Toronto Unit is only staffed with nurses on a part-time, daytime only, five-day week basis, a controller is on call at all times. He calls in nurses and doctors from the lists of personnel prepared to work on the unit.

The doctor on call is usually contacted first, and only he can approve a dive. He arranges for the other staff to be called in. Either the doctor or a nurse dives with the patient, and another medical staff member (either doctor or nurse) must be on hand outside the chamber with the controller.

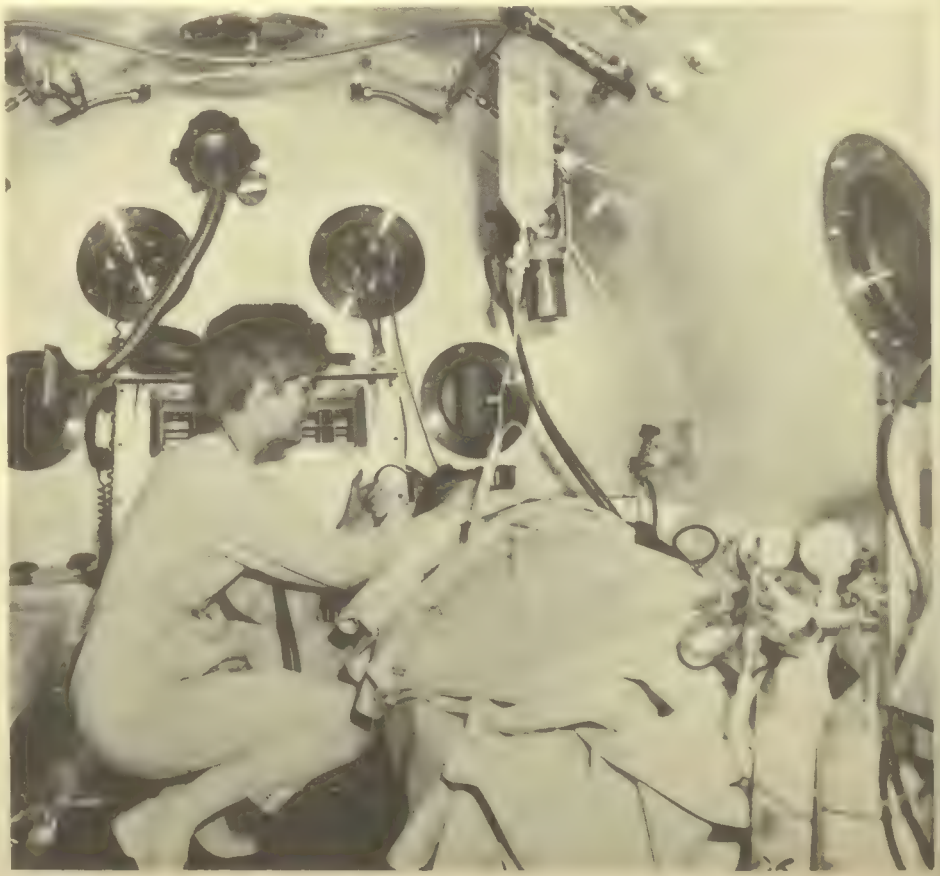
When the young patient with gas gangrene, mentioned at the beginning of the article, arrived at the Toronto General's emergency department, the hyperbaric unit staff were called in. Within one hour he was in the chamber. The doctor "went down" with him; one nurse and two controllers were on hand outside the chamber. "We really didn't have time to do any psychological preparation as the patient was too ill to wait, but the staff tried to explain fully as they went along," said Mrs. Kent. "He was only semiconscious, and delirious at times. He had a myringotomy in emergency to help relieve any ear pressure."

This patient was taken to 66 feet (three atmospheres) very quickly. He then went on 100 percent oxygen for about 60 minutes. The improvement in his condition was dramatic, and after decompression he was taken to the operating room for debridement.

Immediately following the operation, he was returned to the chamber for another hyperbaric oxygen treatment, and these were repeated every four to six hours for a few more dives. The hyperbaric oxygen treatment saved his life. □



The chamber at the Toronto General Hospital is large enough for a patient and one or two staff. A small entrance chamber permits another staff member to enter after the main chamber has been pressurized.



There's not much extra room inside the chamber – everything must be in its specific place. In this photo, the nurse is wearing fire-resistant clothing.

Clinical Laboratory Procedures

This is a 1969 revision of the summary first published in 1949 and subsequently brought up-to-date in 1956 and 1960.

E.M. Watson, M.D., F.R.C.P. (C)

Revised by A.H. Neufeld, M.D., Ph.D., F.C.I.C.

Everyone associated with the activities of a large, modern general hospital must be impressed and at times confused by the increasing number of laboratory tests that are performed on patients. It is, therefore, pertinent that the interest of the nursing staff in laboratory investigations should not be limited to mere formalities such as filling out requisition forms, directing the technician or the I.V. nurse to the proper patient, and collecting and labelling of specimens. While these functions represent important responsibilities of the nurse in relation to the proper conduct of laboratory tests, no doubt she will exert a more intelligent interest in her duties and have a better understanding of the patient if she possesses some knowledge of the procedures that are carried out. With a view to supplying relevant information in a condensed form, the following tables are presented.

The arrangement has been changed appreciably since the last revision. This is based largely on the usual functional and administrative divisions in the up-to-date hospital laboratory. The following order is not necessarily in order of importance.

Hematological values
Blood, plasma or serum biochemistry values
Urine biochemistry values
Cerebrospinal fluid values
Blood Bank values
Function tests and investigations

Tests identified by proper names

Frequently laboratory tests are ordered by using only the man's name, even though other terms might apply equally well and actually should have been used. Technical and analytical procedures often are known best by the names of the men who discovered them or were associated with their development and popularization. The most commonly used terms encountered follow:

Bence-Jones protein — the abnormal protein found in the urine of about 50 percent of patients with myeloma

Bodansky unit — the amount of phosphatase required to liberate 1 mg. of phosphorus; test result for alkaline or acid phosphatases (see also Sigma)

Coombs — a test used in pregnant women and newborn infants relative to Rh sensitization; also used in hemolytic anemias

Duke — a method for determining the bleeding time of a patient

Fishberg (concentration or dilution test) — kidney function test to evaluate the kidney's ability to concentrate or dilute urine

Frei — a skin test for a venereal disease, lymphopathia venereum

Friedman — a test for pregnancy

Hinton — a test for syphilis

Ivy — a method for determining the bleeding time of a patient

Kahn — a test for syphilis

Kepler or Kepler-Power — procedures for the diagnosis of Addison's disease

King-Armstrong unit — an amount of phosphatase required to liberate 1 mg. of phenol; test result for alkaline or acid phosphatases

Kline — a test for syphilis

Kolmer — a test for syphilis

Lange's Colloidal Gold — a test on C.S.F. as an aid in diagnosis

Lee and White — a test of blood coagulation time, using venous blood

Mosenthal — a two-hour specific gravity volume test for evaluating kidney function

Papanicolaou — a technique for the identification of cancer cells

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Quick — a technique for estimating prothrombin (refers to a man's name, not speed of performance)
Paul-Bunnell — a serological test for infectious mononucleosis
Rumple-Leede — not a laboratory test, but a method for determining capillary fragility by inflating a blood pressure cuff and counting the petechiae in a circumscribed area of skin
Schilling — a radioisotope test for pernicious anemia
Sigma — the amount of phosphatase required to liberate 1 mg. of phosphorus; test result for alkaline or acid phosphatases (see also *Bodansky)*
Singer — latex fixation test used in connection with rheumatoid arthritis
Somogyi — often referred to in relation to serum amylase
Sulkowitch — a test for calcium in urine
Van den Bergh — a test for liver function
Wassermann — the original test for syphilis
Watson — a test for urobilinogen in urine and feces
Westergren — a technique for performing the sedimentation rate
Widal — a serological test for typhoid and paratyphoid fevers
Wintrobe — a special tube for determining red cell volume and sedimentation rate
Ziehl-Neelsen — a stain for acid-fast bacteria, usually for tubercle bacilli

Abbreviations and symbols

ABO — the main blood group system
Ac. — acid
A.C.D. — anticoagulant used in preserved blood
A.C.T.H. — Adrenocorticotrophic hormone
A:G ratio — a figure obtained by dividing the value for the plasma or serum albumin by that for the globulin
Alk. — alkaline
A.-Z. test — Ascheim-Zondek, a test for pregnancy
A.F.B. — acid-fast bacillus; a characteristic staining quality of the tubercle bacillus
Av. — average
B.M.R. — basal metabolic rate
B.S. — blood sugar
B.S.P. — bromsulphalein; a liver function test
B.T. — bleeding time
B.U.N. — blood urea nitrogen
C. — centigrade
Ca. — calcium
cc. — cubic centimeter
C.C.F. — cephalin-cholesterol flocculation test; a liver function test
Cl. — chlorine
CO_2C.P. — carbon dioxide combining power of blood plasma
C.P.K. — the enzyme creatine phosphokinase
Creat. — creatinine; a constituent of blood and urine
C.R.P. — C-reactive protein
C.S.F. — cerebrospinal fluid
Cu. — copper
C.V.I. — cell volume index
Diff. — differential; used with reference to a smear of blood or C.S.F. to determine the types and percentages of the white blood cells present
ECG or EKG — electrocardiogram
EDTA — an anticoagulant, frequently used n blood samples for hematology
EEG — electroencephalogram
Eos. — eosinophile; a variety of white blood cell
E.S.R. — erythrocyte sedimentation rate; sedimentation rate
F. — Fahrenheit
F.B.S. — fasting blood sugar
Fe. — iron
F.S.H. — follicle stimulating hormone of the pituitary gland
g. or gm. — gram
G.A. — gastric analysis
G.C. — gonococcus; the causative organism of gonorrhea
g.i. — gastrointestinal
HCG — human chorionic gonadotrophic factor. This factor is present in pregnancy (pregnancy test) and malignant tumors of the testes
Hg. or Hgb. — hemoglobin
H. & E. — hematoxylin and eosin stain; used in the preparation of pathological material for examination
5HIAA — 5-hydroxyindoleacetic acid
Ht. — hematocrit
Ig — the blood immunoglobulins, such as IgA, IgG, IgM, etc.
I.I. — icteric index; a chemical test on serum to reveal the degree of jaundice
ICDH — isocitric dehydrogenase, a tissue enzyme
I.M. — intramuscular
I.V. — intravenous
K. — potassium
17KGS — 17-ketogenicsteroids, a group of hormones in the urine from the adrenal cortex
17KS — 17-ketosteroids; a hormone assay on urine to study adrenal or other glandular disorders
L. or l. — liter
L.D.H. — the enzyme lactic dehydrogenase
L.E. — lupus erythematosus
Lymph. — lymphocyte; a variety of white blood cell
ml. — milliliter; 1/1000 part of a liter; approximately the same as cc. but a more exact expression of measurement
M.C.H. — mean corpuscular hemoglobin
M.D.H.C. — mean corpuscular hemoglobin concentration
M.C.V. — mean corpuscular volume
mEq. — milliequivalent
mEq./l. — milliequivalent per liter
mg. or mgm. — milligram
Myelo — myelocyte; the forerunner of the granular leukocytes
N. — nitrogen
Na. — sodium
Neut. — neutrophiles; a variety of white blood cell
N.P.N. — non-protein nitrogen
O_2 — oxygen
O.T. — old tuberculin; a skin test for tuberculosis
p.a. — pernicious anemia
Pap. stain — Papanicolaou stain for cancer cells
P.B.I. — protein-bound iodine; an estimation used in connection with thyroid function
pH — a symbol used to express acidity and alkalinity
pCO_2 — partial pressure of carbon dioxide
Pl. Ct. — blood platelet count
P.S.P. — phenolsulphonphthalein test; a method for assessing kidney function
R.A. — rheumatoid arthritis
r.b.c. — red blood cell count
R.F. — rheumatoid factor, present in blood in rheumatoid arthritis and occasionally in lupus erythematosis
Rh — Rhesus; the Rh factor
Retic. — reticulocyte
RISA — radio iodinated serum albumin, a material for measuring plasma volume
S.G.O.T. — serum glutamic-oxalacetic transaminase
S.G.P.T. — serum glutamic-pyruvate transaminase
S.I. — saturation index; a test used in hematology
Sp. Gr. — specific gravity
TSH — thyroid stimulating hormone of the pituitary gland
T_3 — an *in vitro* test for thyroid function
T_4 — a test for thyroxine, the thyroid hormone
T.P.I. — Treponema pallidum immobilization: a specific test of serum for syphilis
U.A. — urine analysis
Ur. Ac. — uric acid
μ — micro
$\mu\mu$ — micro micro
VMA — Vanilmandaelic acid, a test for adrenal medulla function
w.b.c. — white blood cell count
W.R. — Wassermann reaction
V.D.R.L. — flocculation test for syphilis

Hematological Values

Most hematological analyses are carried out on blood collected either in a potassium-ammonium oxylate or in EDTA. Exceptions to this are the prothrombin and partial thromplastin time, collected in fluid anticoagulant, and the LE preparation on clottea blood. Usually from 3-7 ml. is adequate for analyses.

Determination	Normal Value	Clinical Significance
Autohemolysis	0.5-3.6% without glucose 0.1-0.8% with glucose	differential test for certain anemias (spherocytoxic)
Bleeding time (Duke)	1-3 min.	prolonged when platelets reduced (as in thrombocytopenia purpura)
Blood volume	60-90 ml./kg.	increased in polycythemia vera; decreased in dehydration, shock, hemorrhage, postoperatively, etc.
Carbon monoxide hemoglobin	none	in carbon monoxide poisoning or intoxication (car exhaust, etc.)
Clot retraction	complete and perfect in 24 hours	delayed and imperfect in thrombo-cytopenia purpura (platelet deficiency)
Coagulation (clotting time)	8-18 min. (test tube method); 1-5 min. (capillary tube method)	prolonged in hemophilia, also after heparin administration
Differential white cell count	Mature neutrophils 52-70%; 3,000-6,000 cu.mm. Young neutrophils 3-5%; 150-400 Eosinophils 1-4%; 50-400 Basophils 0-1.5%; 15-150 Lymphocites 20-35% (up to 50%; in children) 1,500-3,000 monocytes 2-6%; 100-600	increased in many infections; decreased in agranulocytosis increased in many allergic conditions increased in lymphocytic leukemia, infectious mononucleosis and whooping cough
Fibrinogen	200-500 mg./100 ml. Fibrindex — less than 60 sec.	decreased or prolonged in severe liver disease and in a complication of pregnancy
Folic acid	5-21 mμg./ml.	decreased in some of the anemias
Hemoglobin	Adult male: 14-17.5 g./100 ml. Adult female: 12-15.5 g./100 ml. Children: 11-13 g./100 ml. Infants (1 day to 2 weeks): 15-22 g./100 ml.	decreased in the anemias; increased in polycythemia and hemo-concentration (shock, burns, myocardial infarction) decreased in hemolytic disease of the newborn (erythroblastosis)

Determination	Normal Value	Clinical Significance
Hematocrit	Male: 40-54% Female: 37-47%	decreased in the anemias; increased in polycythemia and hemoconcentration
Iron binding capacity	220-400 μg./100 ml.	decreased in hemolytic anemia and hemochromatosis
L.E. preparation	none	positive in lupus erythematosis
Mean corpuscular hemoglobin	27-32 μμg	increased in macrocytic anemia (e.g. pernicious anemia); low in hypochromic anemia
Mean corpuscular hemoglobin concentration	33-38%	same as above
Mean corpuscular volume	80-94/cu. μ	same as above
Paul-Bunnell (heterophile antibodies)	negative	a test for infectious mononucleosis
Partial thromboplastin time (PTT)	0.34% 40-60 sec.	a test for hemophilia-like states
Prothrombin time	12-16 sec., reported with control	mainly used in control of anticoagulant therapy
Plasma hemoglobin	0-4.0 mg./100 ml.	increased in hemolytic anemia and other hemorrhagic processes (mismatched blood, etc.)
Plasma volume	34-60 ml./kg.	decreased in hemoconcentration; increased in some with hypertension, Paget's disease and some other clinical conditions
Platelets	150,000-450,000/cu. mm.	decreased in thrombocytopenia purpura and other clinical conditions
Radioiron clearance (^{59}Fe)	T 1/2 — 120 min.	decreased in iron deficiency; increased in hemosiderosis and aplastic anemia
Red blood cell count	Adult male: 4-5 million/cu.mm. Adult female: 4-5 million/cu.mm. Infants: 5-7 million/cu.mm. at birth, gradually decreasing to adult at 15 years	decreased in the anemias; increased in polycythemia and hemoconcentration (shock, burns, myocardial infarction)

Determination	Normal Value	Clinical Significance
Red blood cell volume (^{131}I)	29-33 ml./kg.	decreased in blood loss; increased in polycythemia vera and hemoconcentration
Red cell fragility (osmotic fragility test)	hemolysis begins at 0.43% NaCl hemolysis complete at 0.34-0.3% NaCl	fragility increased in hemolytic jaundice; decreased in obstructive jaundice
Plasma iron incorporation (^{59}Fe)	75% and over in 7-10 days	decreased in hemolytic anemia; a measure of the rate of formation of red blood cells
Plasma iron turnover (^{59}Fe)	0.061 mg./day/g.Hg.	important in study of iron metabolism
Red cell survival test (with ^{51}Cr)	Half-life: 25-35 days	decreased in hemolytic anemias; a test for the life span of the red blood cell
Reticulocytes	0.5-1.5% of all red blood cells	increased in pernicious anemia following Vitamin B12 therapy and in hemolytic anemias; decreased in aplastic and pernicious anemia
Schilling test (radio cobalt Vitamin B12)	10% and over (urinary excretion)	this is a specific test for pernicious anemia
Sedimentation rate (Westergren)	Male: 0-9 mm./hr. Female: 0-20 mm./hr.	increased in infectious and inflammatory diseases
Total body water (tritium space)	50-70% of body weight	increased in edema; decreased in hemoconcentration (burns, shock, etc.)
Vitamin B12	42-410 $\mu\mu$g./ml.	increased in acute and chronic leukemia, infectious hepatitis, liver cirrhosis; decreased in the anemias, malabsorption, malnutrition

Blood, Plasma or Serum Biochemistry Values

In the majority of hospitals, all biochemistry analyses are carried out on serum. However, some hospitals still use oxylated blood for ammonia, B.U.N. glucose and N.P.N. Amounts of blood required for the analyses range from 5-10 ml.

Determination	Normal Value	Note	Clinical Significance
Aldolase	Male: less than 33 u. Female: less than 19 u.		increased in viral hepatitis, progressive muscular dystrophy, myocardial infarction

Determination	Normal Value	Note	Clinical Significance
Ammonia	10-30 μg./100 ml.	test must be done immediately	increased in severe liver disease and bleeding into gastrointestinal tract, especially from esophageal varices
Amylase	60-160 Somogyi u./ 100 ml.	do not draw during or just following i.v. glucose or after administration of morphine	increased in acute pancreatitis; also in parotitis, perforated peptic ulcer, abdominal trauma, after morphine, etc.
Ascorbic acid (Vitamin C)	0.6-1.2 mg./100 ml.	blood must be placed in a tube surrounded by ice and sent immediately to the laboratory	low in scurvy
Bicarbonate	18-25 mEq./l.	blood must be drawn without stasis from tournique	reduced in acidosis; increased in alkalosis
Bilirubin (Van den Bergh test), total	0.1-0.8 mg./100 ml.		increased in jaundice; latent jaundice 0.5-2.0; clinical jaundice above 2.0
Bilirubin, Direct	0-0.2 mg./100 ml.		increased in obstructive jaundice
Bromide	0-1.5 mg./100 ml.		important in the diagnosis of bromide poisoning
Calcium	9-11 mg./100 ml. 4.5-5.7 mEq./l.		low in hypoparathyroidism, sprue and steatorrhea; increased in hyperparathyroidism and some bone diseases
Carbon dioxide, CO_2	25-35 mEq./l.		increased in alkalosis (respiratory obstruction, vomiting, ingestion of bicarbonate); decreased in acidosis (diabetes, over breathing, etc.)
Carbon dioxide partial pressure, pCO_2	35-45 mm.		same as above

Determination	Normal Value	Note	Clinical Significance
CO_2 combining power	55-75 vol. %		see Bicarbonate above
Ceruloplasmin	30-35 mg./100 ml.		decreased in Wilson's disease
Chlorides	96-105 mEq./l.		decreased in vomiting, starvation and after gastrointestinal surgery
Cholesterol, Total	Adults: 150-275 mg./100 ml. Children: 100-225 mg./100 ml. Infants: 70-125 mg./100 ml.		increased in hypothyroidism, diabetes and nephrosis; also in conditions associated with hyperlipemia; in hypercholesterolemia
Cholesterol, Free	50-60 mg./100 ml.		same as above
Cholinesterase	0.62-1.26 u.		decreased in hepatocellular jaundice, advanced cirrhosis, after hepatotoxic agents
Copper	80-120 μg./100 ml.		decreased in Wilson's disease (hepatolenticular degeneration)
Creatinine	1-2 mg./100 ml.		increased in severe nephritis
Creatine phosphokinase	up to 0.72 milli u.		increased in muscle wasting disease, muscle trauma, pulmonary infarction
C-reactive protein	negative		increased in rheumatic fever, rheumatoid arthritis, lupus, myocardial infarction, pneumonia, pregnancy, etc.
Glucose (fasting)	70-100 mg./100 ml.; total reducing substance 80-120 mg./100 ml.	up to 140 or 160 after meals	increased in diabetes mellitus, Cushing's disease; decreased in hyperinsulinism
17-Hydroxycorticosteroids	5-20 μg./100 ml.	heparinized blood	increased in Cushing's disease, moderate in infections, burns, surgery; decreased in Addison's, etc.
Iron	50-200 μg./100 ml.		increased in hemolytic anemias, hemochromatosis; decreased in iron deficiency anemia

Determination	Normal Value	Note	Clinical Significance
Isocitric dehydrogenase (ICDH)	50-260 u.		increased in diseases of the liver
Lactic dehydrogenase (L.D.H.)	up to 450 u.		increased in myocardial infarction, liver diseases, etc.
Lipase	0.2-1.5 u.		increased in acute pancreatitis
Lipids (total)	450-850 mg./100 ml.		increased in diabetes, xanthomatosis, hyperlipemia
Magnesium	1.3-2.5 mEq./l.	draw in polyethylene tube	changed in various unrelated diseases; also magnesium poisoning
Non-protein nitrogen (NPN)	25-35 mg./100 ml.		see B.U.N. above
pH	7.35-7.45	drawn in a special syringe without stasis	increased in uncompensatec alkalosis; decreased in uncompensated acidosis
Phenylalanine	0-3.0 mg./100 ml.		increased in certain mental diseases
Phosphatase, acid	0.13-0.63 Sigma u./ 100 ml. 0.2-0.8 Bodansky u./ 100 ml. 1-4 King-Armstrong u./100 ml.		increased in cancer of the prostate with metastases of bone; also in hemolysed serum
Phosphatase, alkaline	0.8-2.3 Sigma u./ 100 ml. 1-4 Bodansky u./ 100 ml. 3-13 King-Armstrong u./100 ml. Child: 2.8-6.7 Sigma u./100 ml.		increased in hyperparathyroidism and in biliary obstruction, rickets
Phosphorus, inorganic	Adult: 2-4.5 mg./ 100 ml. Child: 4-6.5 mg./ 100 ml.		increased in severe nephritis and sometimes in rickets; decreased in conditions in which serum calcium is elevated
Phospholipids	230-300 mg./100 ml.		important in relation to disorders involving fat metabolism

Determination	Normal Value	Note	Clinical Significance
Potassium	3.5-5 mEq./l.	serum must be separated from the cells within one hour	increased in renal failure and severe Addison's disease; decreased in diabetic coma
Proteins, adult by electrophoresis			decreased as a result of marked and prolonged albuminuria, nephritis, liver disease, starvation causing edema; increased in infections, pneumonia, multiple myeloma, etc.
total	6-8 g./100 ml.		
Albumin	3.2-5.6 g./100 ml.		
Globulins	1.2-3.2 g./100 ml.		
Alpha 1	0.1-0.4 g./100 ml.		
Alpha 2	0.4-1.2 g./100 ml.		
Beta	0.4-1.0 g./100 ml.		
Gamma	0.4-1.5 g./100 ml.		
Fibrinogen	0.2-0.5 g./100 ml.		
Newborn:			
Albumin	3.3-5.1 g./100 ml.		
alpha 1	0.12-0.32 g./100 ml.		
alpha 2	0.25-0.47 g./100 ml.		
beta	0.17-0.61 g./100 ml.		
gamma	0.4-1.41 g./100 ml.		
1 year:			
Albumin	4.0-5.0 g./100 ml.		
alpha 1	0.15-0.35 g./100 ml.		
alpha 2	0.5-1.11 g./100 ml.		
beta	0.52-0.83 g./100 ml.		
gamma	0.45-0.66 g./100 ml.		
over 4 years:			
Albumin	3.7-5.5 g./100 ml.		
alpha 1	0.12-0.3 g./100 ml.		
alpha 2	0.35-0.95 g./100 ml.		
beta	0.47-0.92 g./100 ml.		
gamma	0.53-1.2 g./100 ml.		
Protein bound iodine (PBI)	4-8 μg./100 ml.		increased in hyperthyroidism
Sodium	133-148 mEq./l.		increased after injudicial use of NaCl solution in patients with impaired kidney function; decreased in vomiting, gastrointestinal disorders, tube drainage (postop), diabetic coma, Addison's disease
Transaminase S.G.O.T.	5.40 Ku		increased in myocardial infarction and infectious hepatitis
Transaminase S.G.P.T.	5-35 Ku		increased in acute hepatitis and relapsing cirrhosis of the liver
Triglycerides	0-150 mg./100 ml.		increased in diseases associated with hyperlipemia (diabetes, xanthematosis, biliary cirrhosis, etc.)

Determination	Normal Value	Note	Clinical Significance
Uric acid	2.5-5.5 mg./100 ml.		increased in acute gout, in nephritis and leukemia, frequently in myelomatosis

Urine Biochemistry Values

Determination	Normal Value	Specimen Req.	Note	Clinical Significance
Amylase	60-225 Somogyi units/100 ml.	Random		increased in acute pancreatitis
Calcium	50-300 mg./ 24 hr.	24 hr.	patient must be on special diet	increased in hyper-parathyroidism, myelomatosis, etc.
Catecholamines	up to 103 μg./ 24 hr.	24 hr.		increased in adrenal medulla tumors
Chlorides	170-250 mEq./l.	Random		important in controlling saline administration
Copper	up to 70 μg./ 24 hr.	24 hr.	preserve in polyethylene bottle	increased in Wilson's disease
Coproporphyrins	50-300 μg./ 24 hr.	24 hr.	preserve in polyethylene bottle	increased in the porphyrias
Creatine	0-100 mg./ 24 hr.	24 hr.	preserve in toluene	used in the study of muscle diseases
Creatinine	0.8-1.5 g./ 24 hr.	24 hr.	preserve in toluene	normally excretion constant; altered in certain muscle diseaases
Follicle Stimulating Hormone (F.S.H.)	before puberty: less than 6.5; Mouse u./24 hr. after puberty: 6.5-52; after menopause: 96-600	24 hr.		important in the investigation of endocrine disturbances
Estrogens	ovulatory cycle: 4-64 μg./24 hr.; normal male: 4-25 μg./24 hr.; pre-pubertal male and female: 4-25 μg./24 hr.; post-menopausal: 0-5 μg./24 hr.; pregnancy (3rd trimester): 26-60 mg./24 hr.	24 hr.	preserve in polyethylene bottle, keep cool	increased in tumors of the ovaries; decreased in ovarian and pituitary malfunction

Determination	Normal Value	Specimen Req.	Note	Clinical Significance
17-hydroxy-corticoids	female: 5-18 mg./24 hr. male: 8-25 mg./24 hr.	24 hr.	preserve in polyethylene bottle, keep cool	important in the investigation of adrenal and testicular malfunctions
5-hydroxy-indole-acetic acid (Serotonin)	60-160 μg./ 24 hr.	24 hr.	patient must avoid eating bananas during collection	increased in carcinoid tumors
17-keto-steroids	under 10 yr.: 0-4 mg./24 hr.; 10-15 yr.: 3-10 mg./24 hr.; Adult female: 2-17 mg./24 hr.; Adult male: 3-23 mg./24 hr.	24 hr.	preserve in polyethylene bottle, keep cool	important in the investigation of endocrine disturbances (adrenal, testes)
Lead	0-0.12 mg./24 hr.	24 hr.	preserve in polyethylene bottle	increased in lead intoxication
Potassium	25-100 mEq./l.	24 hr.	varies with dietary intake	useful in the study of renal and adrenal disturbance, water and acid-base balance
Pregnanediol	female: 3-10 mg./24 hr. male: 0-1.5 mg./24 hr.	24 hr.	preserve in polyethylene bottle, keep cool	increased in corpus luteum cysts and some adrenal cortical tumors; decreased in threatened abortions
Sodium	130-260 mEq./l.	24 hr.	varies with salt intake	same as potassium
Urea nitrogen	8-15 g./24 hr.	24 hr.	preserve in toluene	important in the investigation of metabolic disturbances
Uric acid	0.4-1.0 g./ 24 hr.	24 hr.	preserve in toluene	useful in the investigation of metabolic disturbances
Urobilinogen	Qualit.: Pos. in 1:20 Quant.: 0.5-4 mg./24 hr.	Random or 24 hr.	preserve with sod. carb. under petroleum ether	increased in liver diseases and hemolytic jaundice

Cerebrospinal Fluid Values

Test	Normal Value	Clinical Significance
Color and appearance	clear and colorless; may be slightly blood tinged from needle trauma; no clot	cloudy, turbulent or grossly purulent in meningitis; bloody or yellow when hemorrhage involves CNS

Test	Normal Value	Clinical Significance
Pressure	7-15 mm. Hg. (100-200 mm. of water), pat. lying down; 15-22 mm. Hg. (200-300 mm. of water), pat. sitting up; Child: 3.5-7 mm. Hg. (50-100 mm. of water), pat. lying down	increased in meningitis, edema of the brain, hemorrhage, neurosyphilis; decreased in shock, dehydration and spinal canal block
Cell count	0-5/cu.mm.; all lymphocytes	increased in the various types of meningitis, poliomyelitis, neurosyphilis and encephalitis; pus cells predominate in the acute bacterial processes. Increased lymphocytes in tuberculous meningitis, poliomyelitis and neurosyphilis
Glucose	45-80 mg./100 ml.	increased in diabetes, encephalitis, uremia and sometimes in brain tumor. Decreased in acute meningitis, tuberculous meningitis and insulin shock. Normal values usually found in neurosyphilis
Proteins	15-40 mg./100 ml.	increased in those conditions with an increased cell count (see above); increased in spinal cord tumor and infectious polyneuritis
Chlorides	120-130 mEq./l.	increased in uremia; decreased in tuberculous meningitis
Colloidal Gold test	0000000000	abnormal forms in meningitis and syphilis. Examples: 555554321000, paretic type curve 0244310000, leutic or tabetic type curve 0000245520, meningitis type curve
Globulin test (qualitative)	neg.	increased values in all inflammatory processes of the CNS
Bacteriologic examination	neg.	important in differentiating between bacterial, viral, and other causes of meningitis
Serologic tests for syphilis	neg.	for syphilis

Blood Bank Values

Determination	Values	Clinical Significance
ABO groups	0-45% of population A-40% of population B-10% of population AB-5% of population	essential to determine before blood transfusion

Determination	Values	Clinical Significance
Rh groups	D — Rh pos. 85% of pop. d — Rh neg. 15% of pop.	important in pregnancy. The Rh neg. mother with a possible Rh pos. fetus might lead to erythroblastosis fetalis; also in persons receiving repeated transfusions
Rh phenotypes	D causes most difficulties in transfusion; others (C, E) may cause difficulty in crossmatch	difficulties are picked up in a crossmatch; in rare instances no crossmatch possible and then blood must be given very slowly with close observation
Crossmatch	match ABO group; in the Rh group, D:d	essential in order to eliminate transfusion reaction
Antibody screen	screening procedure for other Rh phenotypes	same as Rh phenotypes
Coombs test	a test for Rh antibodies	Rh neg. mother with Rh pos. fetus may lead to increased antibody to D. Fortunately this can now be eliminated by treating mother at parturition with high titer anti-D serum
Cold agglutinins	when present, these agglutinate patient's red cells	essential to identify; this can be either reversed or weakened by warming the blood to 37°C
Amniotic fluid analysis	test for several chemicals (bilirubin, etc.)	in the Rh mother, tests will show whether fetus is Rh neg. or Rh pos.

Function Tests and Investigations

Tests	Principle	Normal Value	Clinical Significance
AC-PC blood glucose	person's ability to handle dietary carbohydrate	ac: 70-100 mg./100 ml. pc: less than 150 mg./100 ml.	a screening test for diabetes mellitus, Cushing's syndrome, etc.
Glucose tolerance	a test of ability to store and utilize dietary carbohydrate. The standard test, one dose glucose (50 or 100 g.), blood samples 1/2 hr., 1 hr., 2 hr.; occasionally 4, 5, or 6 hr. test required	blood glucose not to exceed 150 mg. and return to normal in 2 hr.	for diagnosis of diabetes mellitus, Cushing's syndrome, dumping syndrome, etc.
Intravenous glucose tolerance	eliminate possibility of impaired absorption from the intestines	blood glucose returns to normal fasting within 1-1 1/2 hr.	same as for glucose tolerance

Tests	Principle	Normal Value	Clinical Significance
Insulin sensitivity test	test of patient's sensitivity to insulin, to promote withdrawal of glucose from blood stream. Dose: 0.25 u./kg. body wt.	blood glucose decreased about 45 mg./100 ml. one hr. after ingestion of glucose with insulin then with glucose alone	test for hypopituitarism, also useful in Addison's disease
Bromsulphalein	Bromsulphalein, after intravenous injection, is excreted almost entirely by the liver	0-7% in 45 min.	a liver function test in patients without jaundice
Cephalin-cholesterol flocculation test	this test depends upon the capacity of the blood serum in patients with parenchymal liver disease to flocculate a suspension of cephalin-cholesterol emulsion	neg. and 1 + in 24 hr.	increased in hepato-cellular and other liver disorders
Galactose tolerance	the liver is the only organ which can convert galactose to glycogen and store it	less than 3 g. of galactose excreted in the urine during a 5 hr. period following ingestion of 40 g. of galactose	a liver function test
Thymol flocculation	an alteration in the plasma proteins in parenchymal liver disease causes precipitation of a solution of thymol	neg. and 1 + in 24 hr.	a liver function test; can be used in patients with jaundice
Thymol turbidity	same as above	0.2-5.0 units	more valuable in the diagnosis of acute than of chronic liver disease
Renal concentration test, diurnal variation	based on the ability of the kidney to properly concentrate urine	morning specimen, spec. gravity 1.023 or higher	valuable in renal diseases, especially slowly developing chronic diseases
Mosenthal test	ability of kidney to concentrate urine after a test meal	night spec. not to exceed 575 ml.; spec. gravity 1.018 and up. Spec. grav. in day specimens should vary by 9 points or more, reaching 1.020 in one or two specimens	same as above
Phenolsulfonpthalein (P.S.P.) excretion	the test is based upon the principle that the normal kidney rapidly and efficiently excretes this dye	30-50% excreted in 15 minutes	principally a test for tubular function; therefore valuable in diseases associated with tubular malfunction

Tests	Principle	Normal Value	Clinical Significance
P.S.P. fractional	same as above	60% and over in 2 hr.	same as above
Creatinine clearance	measure rate of elimination of creatinine by the kidney	90 ml. and over/ min.	this is a test for glomerular function. Important in diseases associated with glomerular malfunction
Inulin clearance	inulin is excreted only by glomerular filtration; the test is a measure of rate of excretion of intravenously administered inulin	the amount of inulin contained in 100-150 ml. of plasma excreted per min.	a more specific test than creatinine clearance
Urea clearance	a measure of the rate of elimination of urea by the kidney	60-95 ml. of blood/min.	urea is filtered by the glomerules and part reabsorbed by the tubules. It, therefore, is of limited value in diseases of the kidney
GI absorption test with triolein ^{131}I	triolein is administered by mouth; it is digested in the GI tract by pancreatic lipase and absorption facilitated by bile	8% and over in the 4th, 5th and 6th hr.	a test for malfunction of bile and pancreas. Therefore, important in diseases of the liver and pancreas
GI absorption with oleic acid ^{131}I	oleic acid is given by mouth and absorption requires the presence of bile	same as above	a test for normal production and secretion of bile; therefore, useful in diseases of the liver, and, with triolein, eliminates diseases of the pancreas
Xylose tolerance	xylose, a pentose sugar, is absorbed from the intestine by diffusion and not metabolised; xylose dose given by mouth	1 hr.: 29-49 mg./100 ml.; 2 hr.: 20-60 5 hr.: 8-16 5 hr.: urine xylose: 4-8 g.	a useful test for gastrointestinal absorption in absence of renal disease
ACTH stimulation	ACTH hormone stimulates the adrenal cortex to secrete corticosteroids	increase of 8-16 mg./day of 17-hydroxycorticoids; increase of 4-8 mg./ day of 17-ketosteroids	very useful to differentiate diseases of the pituitary and of the adrenal cortex (Cushing's syndrome, etc.)
Congo Red	amyloid tissue has considerable selective affinity for Congo Red. The dye is injected intravenously and concentration measured serially in blood	35% or less retention	valuable in the differential diagnosis of amyloid disease, primary and secondary

Tests	Principle	Normal Value	Clinical Significance
Gastric function	measure of acidity of fasting gastric contents and serial samples after a test meal (with or without histamine)	fasting residual 5-100 ml.; after test meal 30-300 ml. first hour; titratable HCl Female: 0-25 mEq./l./hr. Male: 0-48 mEq./l./hr.	valuable test in diseases of the stomach
Maximal histamine gastric secretion	this is a modification of above and must be carried out with great care. The patient is given a large dose of antihistamine followed by a large dose of histamine. The principle is to create maximum response of the stomach	Female basal: 0.5-2 mEq./l. post-histamine: 10-24 mEq./l. Male basal: 1-3 mEq./l. post-histamine: 10-30 mEq./l.	same as above
The LE test (Paratoluene sulphonic acid test)	in certain diseases abnormal granulocytes appear in the blood containing a large amount of nuclear material	neg.	positive results are in lupus erythematosis, liver disease, myelomatosis, and occasionally rheumatoid arthritis
Sweat test	in certain diseases of the pancreas there is excess secretion of sodium chloride in the sweat	sodium 10-80 mEq./l. chloride 4-60 mEq./l.	increased sodium and chloride in the sweat in fibrocystic diseases of the pancreas (mucoviscidosis)
Fecal fat	most dietary fat is digested and absorbed; increase in fecal fat is, therefore, significant	1-7 g./24 hr. 7-25% (dry weight)	increased amount in sprue, steatorrhea, etc.
Fecal bacteriology	to establish presence of abnormal bacteria in GI tract; specimen must be fresh	reported as "normal flora" and any abnormal organisms	differential diagnosis in diseases associated with diarrhea
Fecal mycology	to verify presence of ameba, etc. in GI tract; specimen must be fresh	presence of ova or spores reported	same as above

Student observation at postmortem examinations

Is observation of postmortem examinations helpful in supplementing a nursing student's knowledge of anatomy, physiology, and pathology? How many schools of nursing in Canada encourage their students to attend these examinations? THE CANADIAN NURSE sent questionnaires to the educational directors of 154 English-language schools of nursing in Canada to attempt to answer these questions.

V.A. Lindabury

The question of whether nursing students should be encouraged – or even allowed – to attend postmortem examinations as part of their clinical experience has long been debated by nurse educators. In conversation and in writing, most educators reveal strong feelings either in favor of or against the inclusion of this experience in the nursing curriculum.

Frequently the response of nurse educators is colored by their own reactions to autopsies they attended when they were students. As one respondent wrote, "I found this a most distasteful experience when I was a student. Because of this, I discourage my students from attending postmortems . . . ."

Questionnaire

One hundred and fifty-four questionnaires were sent to English-language schools of nursing. The first question asked respondents to check one of the following to indicate their school's policy on student observation of autopsies: (a) it is compulsory for each student to attend a given number of postmortem examinations; or (b) it is not compulsory, but students may attend at their own request, if the instructor considers it a worthwhile educational experience; or (c) students are not allowed to attend postmortem examinations. The respondents were then asked to explain their reasons for the policy they had checked.

The remaining questions were directed to those respondents who had checked (a) or (b) above. These respondents were asked if instruction were given to the students during the autopsy and, if it were, by whom. They were also asked to indicate whether students are required to submit a written report following their observation.

The final question asked the nurse educators to indicate how nursing students react to their observations of an autopsy. For example, do students find this experience helpful? In what way? Are they upset by this observation?

Results of first question

One hundred and thirty-five of the 154 questionnaires sent out were returned, a response rate of 87.6 percent. Of these, 6 respondents (4.4 percent) stated that their schools had no policy concerning student observation at postmortem examinations: two gave no reason for the absence of a policy, and four stated that the school's faculty was still in the process of constructing the curriculum.

Three respondents (2.2 percent) said that it was compulsory for students to attend a given number of postmortem examinations during their educational program. Ninety-two respondents (68.1 percent) said it was not compulsory for students to attend these examinations, but that students could attend at their own request if the instructor considered it a worthwhile educational experience. Thirty-four respondents (25.2 percent)

Miss Lindabury is Editor of THE CANADIAN NURSE. She acknowledges with thanks the assistance of the 135 educational directors who responded to this questionnaire.

stated that students were not allowed to attend autopsies.

Reasons given

The three respondents who said that student observation of a postmortem examination was compulsory in their schools gave almost identical reasons for this policy. They looked on this experience as helpful to the student in her learning of anatomy, physiology, and pathology. One respondent added that the experience ". . . assists [students] in interpreting the purpose and process of this examination to many various individuals."

The 92 respondents who were against compulsory observation, but who allowed it if requested by the student with the instructor's permission, gave similar, but more detailed reasons. One respondent pointed out that students ". . . receive only two weeks observation in the operating room, and therefore do not see as much human body structure as we would like." This respondent believed that observation of an autopsy was a necessary supplement to the student's understanding of body structure and the disease process.

Nine (9.8 percent) of these 92 respondents who allowed their students to observe autopsies had misgivings about it. These respondents said that most of the faculty did not consider this type of observation to be a worthwhile experience for students; however, because the faculty believed students should be given the opportunity to be self-directing, they permitted the student to attend at least one autopsy if she requested it.

Of the 34 respondents who said that observation of autopsies *was not* included as part of the learning experience, five gave no particular reason. Eight reported inadequate facilities, which prevent students from attending postmortem examinations; one said that autopsies are not performed in the hospital where the school is located; and one said, "as a regional school, we are independent of any hospital . . . . " Two respondents said that observation of an autopsy serves only to satisfy "morbid curiosity"; another said that the pathologist is reluctant to have nursing students attend an autopsy. Two other respondents said that the experience was too "traumatic" and "shattering" to be of any educational value to the student. The remainder questioned the value of such an experience and pointed out that the school's objective was to increase interest in nursing care, not in the pathology of disease.

One respondent summed up her faculty's reasons in this way:

"The traditional reason for permitting students to view autopsies is to clarify and otherwise augment their study of anatomy. The reason for performing an autopsy is *not* to teach students, but to determine the cause of death. We do not believe that these two complement each other too well. Although it is a recognized method of study and research for medical students, we do not believe it to be a valid or necessary educational tool by which to teach student nurses gross anatomy.

"The potentially negative variables are these: 1. The age of the student: the age of the patient (child, adolescent, infant, etc.); 2. The extent of the autopsy: [examination of] the cranium is usually very upsetting . . . . ; 3. The attitudes and techniques of the pathologist: the majority are positive, professional, and gentle – but there are others to whom no student nurse should be exposed.

"If the student has been caring for the patient prior to his or her death, the experience is sobering enough for the average student without subjecting her to the sequel of a postmortem. The cause of death can be ascertained later from the doctor, head nurse, or medical-records department.

"If the student has *not* been caring for the patient, the viewing of the postmortem is irrelevant . . . . "

Instruction during autopsy

Of the 95 respondents whose students view autopsies (3 respondents reported compulsory observation; 92 reported that students are allowed to view autopsies, although it is not a compulsory experience), 70 said that the autopsy is explained to the student by the pathologist. In 20 instances, explanation during the autopsy is apparently given by both the pathologist and the instructor. Five of the 95 respondents did not answer this section of the questionnaire.

Twelve respondents reported that a conference with the students is held by the instructor prior to the observation. Seventeen respondents said that a group discussion with the instructor was held following the autopsy. Only four respondents said that students were required to submit written reports of their observations.

Student reactions

Most of the 95 nurse educators who responded to this question believe that students find the observation of a postmortem examination of some assistance in understanding anatomy and the disease process. Almost every respondent added, however, that some students do find the experience upsetting. Two respondents said that careful preparation of the student, similar to the preparation given for other types of clinical experience, helped to minimize any adverse emotional reaction. One respondent said, "Students seem to be able to look on [the postmortem examination] as an objective learning experience after they have overcome their initial distaste."

More than one respondent noted that students are often upset by the sound of the bone cutter; other respondents said that students are more likely to be upset when they had previously nursed the patient on whom the autopsy was being performed.

Twenty of the 95 respondents who indicated that their students observe autopsies stressed the importance of the attitude of the pathologist who teaches the students. They believe the manner in which the pathologist conducts the autopsy influences students' reaction to the procedure, and determines whether it is a true learning experience. As one respondent said, "The attitude of the pathologist is of utmost importance in preserving the dignity most student accord the human being."

Although most nursing students apparently find the observation of autopsies helpful, some of them are left with conflicting feelings. Three respondents said that several students expressed the view that they would not allow an autopsy to be performed on a member of their family, even though they recognized the value of a postmortem examination.

Nursing organization — circa 1969

The time has come to change the traditional organization of nursing service. What better time could there be to put fresh ideas to the test than when a brand new hospital is being planned?

Diane Y. Stewart, M.Sc.N.

"Traditional patterns of nursing organization have served the past well, but they cannot cope with the complexities of modern nursing service." This was the opinion held by the nurses involved in planning the University Hospital, a new teaching hospital to be located on the campus of The University of Western Ontario in London.

The 434-bed hospital is scheduled for completion in the fall of 1971. It will be the final stage in the development of The University of Western Ontario's Health Sciences Centre. The complex will include, under one roof, the Kresge School of Nursing building, the Cancer Research Laboratory, the Medical Sciences Building, and the Dental Sciences building. The University Hospital will contain facilities for a school of medical rehabilitation.

The director of nursing, University Hospital, a permanent member of the hospital planning group, and faculty members of the school of nursing at The University of Western Ontario have been closely involved in all phases of planning the University Hospital. Working with the medical faculty, architects, and planning group members, the nurses have ensured that the new hospital will serve the three principal functions of a university hospital – teaching, research, and service to patients.

Definite ideas about how the department of nursing should be organized have formed the basis of the planners' design of the patient-care areas. Form has followed function in the planning of the entire hospital.

The hospital will be a 10-story structure. The base, consisting of basement and three floors, contains mainly services for the hospital. Superimposed on the base are two connected seven-story towers. On each floor one tower contains two 30-bed inpatient units and related teaching facilities; the other tower contains offices for clinical department heads and their associates, research laboratories, and an outpatient department. Between the two towers is a bank of elevators and facilities for handling the service requirements of the entire floor.

Authority decentralized

When planning the organization of the department of nursing, the following two principles were considered: first, authority should be decentralized from the director of nursing to other nursing staff, and second, nurses should be relieved of non-nursing functions.

Decentralization of authority, that is delegating decision-making to lower levels in the organization, has been an important management principle in industry for over 20 years. Naturally, decentralization of authority is a matter of degree, as basic decisions and policies must receive attention at top levels.*

In most nursing service departments this concept has been overlooked; nursing office supervisors are centrally located and are responsible for most decisions. A decentralized system would relocate supervisors in their area of clinical interest where they would work directly with head nurses and staff and be responsible on a 24-hour basis for organizing, directing, and coordinating nursing functions. In this way, the supervisor would be given the authority and responsibility she should have but would have considerable latitude in exercising independent judgment and initiative.

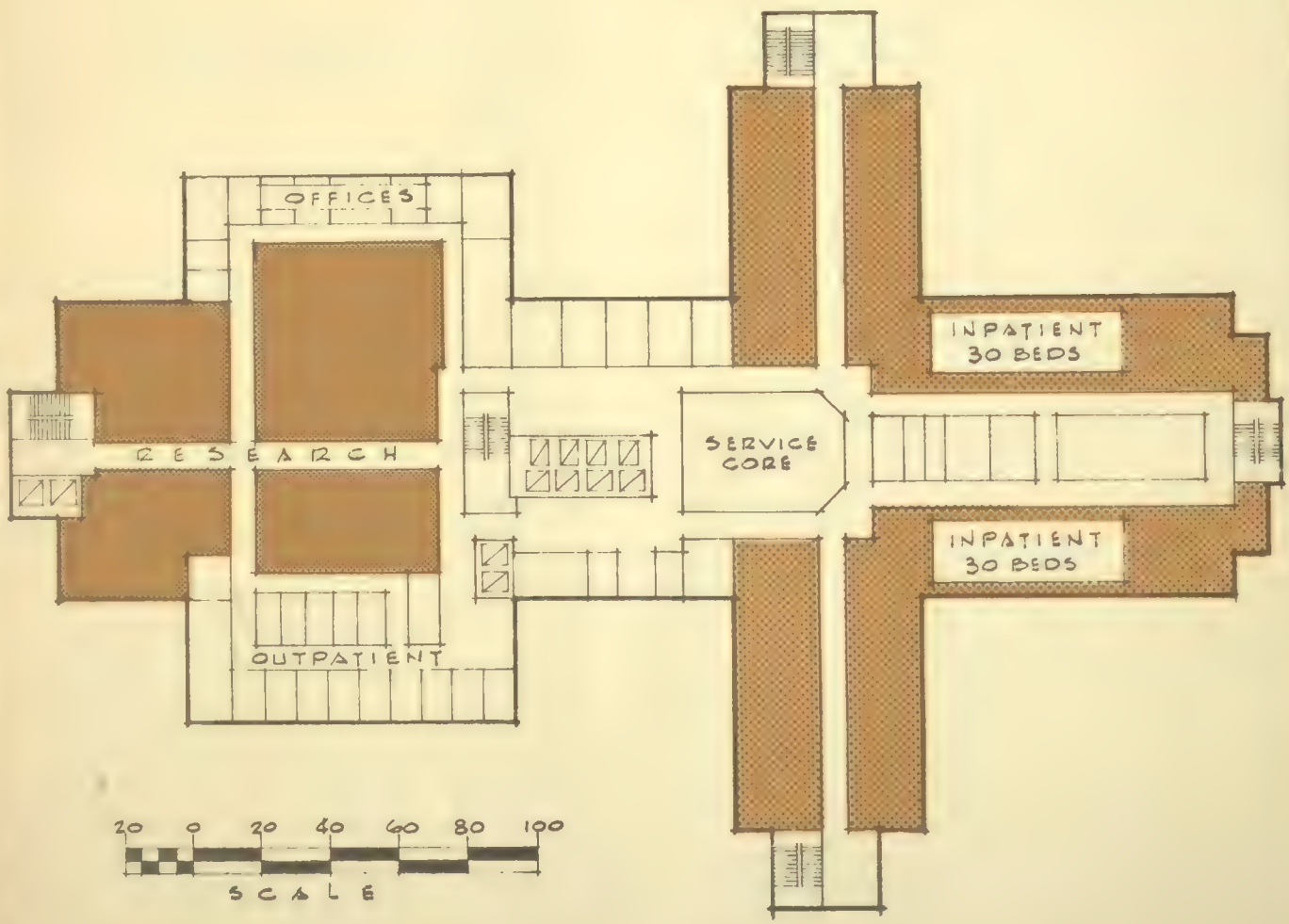
With decentralization of authority the head nurse would be granted increased responsibility for decision-making and planning and coordinating patient care. There would be more involvement of team leaders and staff nurses in the decision-making process. Nurses have repeatedly said that they want to have, and should have, more responsibility. With this structure, they should receive the additional responsibility and so find the work situation much more satisfying.

The director of nursing at University Hospital will be directly responsible to the executive director for directing and coordinating the nursing care of all patients, providing inservice education for nursing personnel, and directing a program of nursing research in the hospital.

Three nurses will be directly respon-

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*Massie, Joseph L. *Essentials of Management.* Englewood Cliffs, N.J., Prentice-Hall Inc., 1964, pp.51-52.



TYPICAL TOWER FLOOR
UNIVERSITY HOSPITAL, LONDON, ONTARIO
TILLMANN & LAMB: ARCHITECTS

sible to the director of nursing:

- The *associate director of nursing* will be responsible for the overall direction and coordination of nursing care of patients in all patient-care areas.
- The *administrator of nursing education* will direct educational activities related to nursing in the hospital and maintain liaison with the University School of Nursing regarding clinical experience for nursing students, and refresher and postgraduate specialty courses for registered nurses.
- The *administrator of nursing research* will be responsible for the research program related to nursing in the hospital. She will cooperate with the nursing staff to identify areas requiring study, and plan and implement programs of nursing research. She will cooperate closely with the faculty of the school of nursing to coordinate research projects and studies, to share facilities and results, and to avoid duplication.

These three nurses and the director of nursing will be the only nursing staff occupying offices in the central nursing administration suite. The remainder of the senior nursing staff will be located on the nursing floors.

Traditional roles changed

This structure involves a change in the traditional roles of both the supervisor and head nurse. For this reason, the titles nursing administrator and nursing coordinator were considered more appropriate and meaningful.

A *nursing administrator* will be located on each of the patient-care floors. Each floor will represent a different service or combination of services. The nursing administrator will be a specialist in her clinical area as well as an administrator. She will be responsible over a 24-hour period, for all inpatient and outpatient nursing activities on her 60-bed floor. At this level – close to the patient – many decisions will be made which, in the past, have been made by supervisors in a central nursing office. There will be no central nursing office supervisors.

Working with the nursing administrator on a floor will be two *nursing coordinators*, one for each 30-bed unit. These nursing coordinators, also specialists in their clinical area, will be responsible for the nursing activities on their unit. They will organize their staff into teams of graduate nurses, registered nursing assistants, and nursing orderlies, with graduate nurses as team leaders on a rotation basis. It is hoped that in the future, nursing orderlies will become registered nursing assistants.

The nurse clinician or clinical specialist concept is both creative and challenging. However, nurses prepared at the master's level are in short supply, particularly those prepared in a clinical specialty. In the University Hospital nurses will be relieved of non-nursing functions and, therefore, should have much more time to spend with the patients. Consequently, the nursing administrator and nursing coordinator, both prepared in a clinical as well as a functional specialty, will have a dual role, but will spend most of their time with staff and patients. This seems to be the most economical and realistic approach to take at this time and should provide a role for senior nursing staff that affords much job satisfaction.

Floor managers

Over the years, as patient care has become more elaborate and extensive, nurses have assumed responsibility for many functions that they have neither the preparation nor the time to perform. To relieve nurses of this myriad of non-nursing functions, the floor manager concept has been proposed for the University Hospital.

One *floor manager*, responsible to the hospital administration, will be located on each floor. His work will involve the entire floor of inpatient and outpatient areas, as well as teaching and research areas. The floor manager will be expected to coordinate efficiently the various hospital services and functions that do not have to be performed by staff responsible for the direct care of patients. He will be responsible for non-nursing functions such as duties related to equipment, supplies, linen, house-keeping, clerical work, maintenance and portering.

The employment of floor managers should allow nurses to spend more time with patients. Ultimately, there should be an improved quality of patient care, a lower turnover of nursing staff, a higher staff morale, and increased job satisfaction.

By decentralizing authority in nursing service and employing floor managers, each floor in the University Hospital should function to a large extent autonomously. A cooperative relationship among the clinical department head or his deputy, the nursing administrator, and the floor manager should provide adequate care and treatment of patients on each floor over a 24-hour period.

The service departments will also be organized in a way that will help ease pressures placed in the past on nursing staff. The dietary department will have complete responsibility for all food services. The pharmacy department will assume full responsibility for the provision of total pharmaceutical services in the hospital, such as the centralized unit-dose medication system, clinical pharmacists, intravenous solution admixture program, and automatic replenishment of controlled drugs. The central processing department will be responsible for providing an adequate complement of linen, equipment, and supplies to all inpatient and outpatient areas, operating and delivery rooms, and research laboratories. Linen and supplies in patient-care areas will be delivered directly to nurse servers in the patients' rooms. These, as well as other improvements, should certainly allow nursing staff to spend more time with patients.

The future

In the University Hospital nurses are attempting to meet the demands placed on nursing service today by anticipating the needs of tomorrow.

This is not a simple chore, but to accept the restrictions of a traditional nursing organizational structure would be sheer regression! □

Two-year versus three-year programs

Do graduates of a two-year hospital nursing program compare favorably with graduates of a three-year program? This is a vital question for nursing at this time. This study reveals some unexpected observations.

C.G. Costello and Sister T. Castonguay

In 1962 the Regina Grey Nuns' Hospital introduced a two-year nursing education program on an experimental basis. It was introduced on the hypothesis that if repetitions were eliminated in classes and learning experiences were carefully selected and well-guided, the student could become a competent nurse in less than three years.

The three-year nursing education program was not discontinued when the experimental two-year program was introduced. To evaluate the respective merit of the two- and three-year programs, a group of students in each program was selected for comparison.

In 1962 and 1963, 20 nurses were assigned to the experimental program and in each year 20 matched controls were assigned to the three-year nursing program. The two groups were matched on age, father's occupation, abstract and verbal reasoning ability, science aptitude, reading ability, and personality variables such as need to achieve, need for change in environment, ability to endure, sense of responsibility, emotional maturity, and self-sufficiency. The matching was done on the basis of measurements from well-established psychological tests.

In addition to the 40 subjects chosen in 1962 and the 40 selected in 1963, three matched groups of special control students were selected from the 1961, 1962, and 1963 classes.

These three matched groups were selected for the purpose of determining whether the two raters who were to rate the performance of the nurses on the ward changed their standards in any way over the years. Such a change would have made it difficult to interpret the findings from the experimental and control groups. No change in the standard of raters was found to have occurred.

Both the experimental and the control students followed a program in which repetitions in classes were eliminated, content was enriched, and concurrent teaching was introduced. A detailed account of the changes in the curriculum is found in the complete report.

Ratings were made by independent raters from outside the hospital who did not know to which group the new graduates belonged; and special control groups were set up so that the effects of the repeated use of the rating scales could be determined.

Dr. Costello is Professor of Psychology at the University of Calgary. Sister Castonguay was Superintendent of Nursing Education, Dept. of Education, Province of Saskatchewan, at the time the article was written.

The analysis of the data obtained in this project was done in 1968 with the assistance of a Canadian Public Health Research Grant no. 608-7-116, and thanks are due to the Alberta Department of Public Health for their approval of the grant. Thanks are due also to the Saskatchewan Department of Public Health for their approval of the expenses incurred in the conducting of the experimental program. A more detailed account of this study may be obtained by writing to Mrs. C.O. O'Shaugnessy, Director, School of Nursing, Regina Grey Nuns' Hospital, Regina Saskatchewan.

Other evaluations

Other evaluations of two-year programs have been carried out and, on the whole, these evaluations have shown that graduates from two-year programs compare favorably with graduates from three-year programs. However, all these evaluation studies have suffered from serious methodological faults. For instance, Lord (1962) presented a report on the evaluation of an experimental program established in Windsor, Ontario, in 1948. Directors of nursing and physicians who observed the nurses at work were asked to rate them in relation to dependability, knowledge of nursing theory, knowledge of nursing practice, attitude to supervision, attitude to patients, all-round ability, and capacity for growth. It was found that, in the opinion of the directors of nursing, 48.3 percent, and in the opinion of the doctors, 40.5 percent of the experimental program graduates were rated better than "other nurses." The director of nursing also rated 50.3 percent of the experimental graduates as "about equal" to other nurses and the physicians considered 61 percent of the experimental graduates to be in this category.

Unfortunately, there were no control students with which one could compare the experimental graduates. Three "control" schools were selected in a manner not identified in the report; two were from Ontario and one was from Saskatchewan. Unfortunately, these control schools were used only for comparison of data concerning students' enrolment and curriculum and not for comparison of the

relative nursing skills of graduates from the program. A further problem lies in the vagueness of some of the dimensions in which the ratings were to be done; for instance "capacity for growth." Perhaps even more serious is the fact that the physicians and nurses doing the ratings were aware of the fact that the graduates were from an experimental program; thus the important single-blind condition was not met. The single-blind condition means that raters are aware of the particular educational program or other experience to which the people being rated have been subject. This is absolutely essential if rater bias is to be avoided.

Similar kinds of criticisms can be made of the studies that have been presented by Schmitt (1957), Mussallem (1959), Gotkin (1956), Gallagher (1956), the Glasgow Royal Infirmary (1963), Montag (1959), and Spaney and her colleagues (1962).

Specific skills rated

To evaluate the experimental and control nurses at Regina Grey Nuns' Hospital, the following measuring devices were used:

1. A scale for the rating of nurses by senior nurses: This was a list of 195 critical incidents related to nursing performance, based on a list developed by Gorham (1962). Each incident was a description of a specific aspect of nursing behavior. Some examples are: "explains ongoing procedures to patients"; "corrects safety hazards in environment"; "double checks medical orders." Such lists of critical incidents are generally considered more reliable than the usual rating scales using abstract concepts such as "is responsible," "is honest," "is conscientious," and so on. This 195-item scale was used to rate the nurses by two independent raters not employed at the Grey Nuns' hospital, who observed the nurses for a period of five days.* The nurses were observed on the ward and an endeavor was made to vary the ward experience in a similar way for all the students. All the students wore the same bands on their nursing caps, so that the group to which they belonged was unknown to the rater.

2. Evaluation of students in a simulated nursing situation: The students were taken individually into the nursing laboratory. Nursing equipment was available and other students played the role of patients. Each student was given, in succession, three descriptions of a nursing situation; each situation was selected at random from one of three groups of situations so that each student had one difficult, one intermediate, and one easy situation.** The students were observed by two supervising nurses at the Grey Nuns' Hospital. These two supervising nurses independently checked whether or not certain required behaviors occurred and also the time taken to carry out the particular nursing procedure.

3. The scores on the State Board Test Pool Examination, the School of Nursing Examinations, and the National League of Nursing Achievement Tests were analyzed.

4. Self-evaluations were made by the students and evaluations were made by their employers after three months and again after one year following graduation.

5. Because it was feared that the experimental students during their education might get preferable treatment because they were experimental students, some check on this was required. To do this, the students in both the experimental and the control groups were asked to evaluate their supervisors using a list of critical incidents. The students were also asked by the use of a technique known as the semantic differential to indicate their attitude to things like the hospital, their supervisors, and the physicians.

Unexpected results

When any student withdrew from the school, whether she were an experimental or a control student, her matched student also had to be withdrawn from the experiment to keep the two groups matched. As a result, some of the comparisons between the experimental and the control group are made on only 24 pairs rather than 40 pairs of students. It should be remembered, however, that the statistical procedures used account for this reduced number of pairs so that the significance of the results is not altered in any way.

As noted previously, by analyzing separately the data on the 1961, 1962, and 1963 special control groups, it was found that the two outside raters did not change significantly in their use of the rating scales. Despite the fact that specific behaviors were being rated, the two raters did differ from one another to quite an extent however, so that the data for the experimental and control students were analyzed separately for the two raters. In both analyses, the control students, that is the three-year students, obtained a higher score for their behavior on the ward. In the case of one of the raters, this difference in favor of the control students was highly significant.

The two observers in the simulated nursing situation agreed almost completely; therefore their observations were combined. The three-year control students did better than the two-year experimental students in all three types of nursing situation: the easy, the intermediate, and the difficult. However, the difference in favor of the control students was only significant for one of the levels – the intermediate. The control students also performed the task more quickly than the experimental students; in two levels – the easy and the difficult – the difference in favor of the control students was significant.

In the State Board examinations, the control students obtained a higher mean mark than the experimental students but only the difference in child nursing was significant. On the School of Nursing examinations control students got better marks than the experimental students in every section but one (surgical nursing). In two sections (obstetrical nursing and psychiatric nursing) the differences were

*We wish to thank our two independent raters, Mrs. Agnes Gunn and Miss Florence Roach, for their assistance.

**Examples of the situations are: 1. Your patient has asthma. She has been dyspneic during the night and the doctor has ordered oxygen by nasal catheter. Please administer nasal oxygen. 2. Mrs. Brown has had a perineal repair five days ago. You are to give her perineal care. 3. Mrs. Jones has just had a complete bed bath. You are assigned to make her occupied bed. She is a 47-year-old housewife hospitalized with chronic anemia.

significant, although psychiatric nursing was not written by all control students. In the National League of Nursing examinations, the control students did better than the experimental students in all sections except one (medical) but none of the differences were statistically significant.

Thirty-nine head nurses were asked to indicate the score they felt a graduate nurse should get on each of the following ten aspects of nursing: application of nursing principles, nursing judgment, conscientiousness, human relations, organizational ability, observational ability reaction under pressure, communication skills, objectivity, flexibility.

In their first evaluation, three months after graduation, the control group obtained a higher mean rating in each of the ten parts. In three parts – communication skills, objectivity, and flexibility – the difference in favor of the control group was significant. The experimental group scored significantly higher than head nurses' expectations in their reaction under pressure, but were significantly lower in their communication skills and objectivity. The control group was significantly higher than head nurses' expectation in their nursing judgment, organizational ability, reaction under pressure, and flexibility.

In the second evaluation, taken 12 months after graduation, a shortened list of critical incidents related to ward behavior was used; again, the control group did significantly better than the experimental students.

The two- and three-year nurses did not differ in their attitudes to the supervising nurses and the hospital situation in general, suggesting that neither group had had preferential treatment.

Conclusive evidence

This study provides conclusive evidence that the students in this three-year program performed better generally than students in the two-year program. To what extent this is due to the difference in the length of the program cannot be determined precisely because the length of the program is confounded to some extent with other differences, such as curriculum differences.

However, in view of the systematic and objective method of evaluation used in this study, the conclusions reached by the observers must be seriously considered. This meticulous method of evaluation may be summarized as follows:

1. The experimental and control groups did not differ initially on any of the matching variables; therefore, any differences found between them on the dependent variables can with some confidence be attributed to the effects of the different programs.

2. The two external raters did not show any systematic change in their ratings over time; this was indicated by the lack of significant differences in the ratings obtained by the students in the three matched special control groups. Therefore, the difference in the ratings by the external examiners can be relied on with some confidence.

3. The control students did better when rated for their ward performance by external raters.

4. The three-year students showed more of the expected behaviors and performed them more quickly in a simulated nursing situation.

5. In the three written examinations – State Board examinations, School of Nursing examinations, and National League of Nursing examinations – the control students did better than the experimental students.

6. The control students obtained better scores in employers' evaluations both three months and 12 months following termination of the course.

7. The scale for evaluating supervising nurses and the semantic differential was included in the study because it was feared that during the course the nursing school faculty might have had a better attitude toward the experimental students. These instruments were designed to detect any differences of this sort. However, the results from the scale for evaluating supervising nurses indicated no differences between the two groups in their perception of supervising nurses. There was one significant difference on the semantic differential but, as has been suggested, because of the multiple comparisons that were made, no great reliance can be put on this.

Interpret results carefully

The contrast in the results obtained by this systematic and objective evaluation study and those of more subjective and less well controlled studies is obvious. The results of this study are much less favorable for two-year programs than the other studies to which we have referred.

The results of this study, however, must be interpreted with care and used with equal care as the basis for practical decision-making.

Some readers may very well feel – and with justification – that though the control groups have done generally better than the experimental students, the difference in favor of the controls is not so marked as to justify an extra year of education. With some modification of the two-year program, the difference in favor of the three-year program may disappear and, indeed, the findings may be completely reversed. It is also important to keep in mind that since the experimental students generally met the head nurses' expectations and the registration requirements, one can with confidence go along with the educational trend of "saving one year" of the student's time.

The very fact that the experimental students were experimental may have put them under greater stress or pushed their drive level beyond an optimum level. It is a well established fact in psychology that too high a drive level will result in deterioration in performance, particularly with complicated tasks (such as nursing) and in the case of relatively inexperienced people (such as new graduates of nursing).

It is not our intention to resort to special pleading. It is true that the findings in favor of the controls, though not overwhelming, were unexpected. By this time, however, several other classes have been admitted to the program and important changes have been introduced in the curriculum. It would be most interesting to make an evaluation of the program as it is offered in 1968, six years after its first introduction into the school.

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books

Marital Breakdown by Jack Dominian. 172 pages. Harmondsworth, England, Penguin Books, 1968. Canadian agent: Longmans Canada Ltd.
Reviewed by Valerie Fournier, Public Relations Officer, Canadian Nurses' Association, Ottawa.

The incidence of separation and divorce continues to rise in the western world. Society is only beginning to realize that the whole area of marital breakdown is a complex and serious problem that needs more study and better solutions, especially since this society is based upon marriage as an institution.

Jack Dominian, a British psychiatrist, explores this area of marriage breakdown and urges society to give more attention to the problem, particularly through research. He presents a selected survey of both sociological and psychological research into marriage conducted in the United States and Britain, and includes his own observations.

Dr. Dominian stresses that the personality and the specific interaction of the couple is the most important factor in a marriage, and that "every major study associates marital disharmony and unhappiness with a high incidence of personality and neurotic difficulties in the partners."

He picks out three traits typical of psychological immaturity that contribute most frequently to marriage breakdown: failure to achieve the minimum of emotional independence; deprivation and insecurity; and failure to achieve enough self-esteem. He goes on to discuss sexual difficulties, birth control, and psychological illness.

Dr. Dominian believes that society has three main responsibilities in the field of marriage. First, it must try to prevent marriages that have little or no chance of success. He mentions particularly the factors of age, premarital pregnancy, and the engagement period, and believes "ultimately prevention must be directed towards an adequate preparation for marriage."

Secondly, society should help in reconciliation, and he believes marriage therapy involves total help with social, material, and health problems. Finally, society should provide an effective system for the dissolution of marriage, and here he discusses the role of religion and the law in regard to marital breakdown.

One drawback for Canadian readers is that Dr. Dominian deals with British divorce laws, regulations, and machinery for counseling, which are in most cases inapplicable to this country.

However, this is not a serious problem, and his sensible, realistic and readable approach to marital breakdown – which applies just as much to Canada as to Britain – should more than make up for it.

Erratum

The book *How to Pass Entrance Examinations for Registered and Graduate Nursing Schools* reviewed on page 51 in the January 1969 issue was erroneously stated as being published by the W.B. Saunders Company, Toronto. The book was published by Cowles Education Corporation, Look Building, 488 Madison Ave., New York, N.Y.

The Unconscious Mind — The Meaning of Freudian Psychology by Benjamin B. Wolman, 244 pages. Scarborough, Ont., Prentice-Hall, Inc., 1968.
Reviewed by Bernard Lubin, Ph.D., Professor, Department of Psychiatry, University of Missouri School of Medicine, Kansas City.

Fifteen years ago, publishers knew that any book on psychoanalysis written by almost any psychoanalyst would be a a profitable venture. Intelligent laymen as well as mental health professionals could be relied upon to react almost by reflex to the magic of the term "psychoanalysis." A major change has occurred since then. From its status as "the" major theory of personality development and method of personality change, psychoanalysis was described recently as "the best method available for training psychoanalysts." The statement says a great deal about the irrelevance of psychoanalysis to many of today's problems. Conceptual models and treatment methods once thought to be "superficial" have been shown to have much more predictive power, to be much less expensive and time-consuming, and to be appropriate for a much larger proportion of the population.

Readable accounts of psychoanalysis, however, are still quite important, whether as essays on recent professional history, or, occasionally, as a source of testable hypotheses. This is an unusually readable and cogent account of the art. As in many of his writings, Dr. Wolman communicates in this work a sense of total grasp of the subject matter and an unusual ability to deal with highly complex material. He writes in an appealing manner without sacrifice to the material itself.

The Process of Patient Teaching in Nursing by Barbara Klug Redman, R.N., B.S.N., M.Ed., Ph.D. 140 pages. Saint Louis, Mosby, 1968.
Reviewed by Sister Mary Irene, Director, School of Nursing, Charlottetown Hospital, P.E.I.

This is a new book designed to provide the student with background knowledge in the vital area of patient learning. In the preface, the author offers this book for the student of nursing who recognizes the need for patient teaching and for the advanced students and graduate nurses who have not had formal instruction in this area. Essential for competence in patient teaching is interaction with the patients being taught and sufficient knowledge of the subject matter.

The text begins with an explanation of the relevance of teaching to nursing. It goes on to present its information in six chapters that focus on the process of teaching-learning. The first chapter, "The Place of Teaching in Nursing" gives a historical background of the topic, highlights the objectives of health teaching, and assesses what is currently being done. It closes with some realistic recommendations for success in reaching the goal of better patient education.

Other chapter topics are: overview of the teacher-learning process; readiness for health education; objectives of health teaching in nursing; learning and teaching, and evaluation of health teaching.

Many plans of instructional methods and techniques are included. The book is well documented and includes an extensive bibliography that is helpful for further study. A few illustrative case studies are also included to help the student gain an insight into the practical application of what she has learned. Study questions are useful as review material. The author emphasizes the need of good patient and family teaching as a basic factor in the healing process. Through her realistic approach to a practical problem and often a neglected responsibility, she has produced a book that should be in every nursing library.

books

History of Nursing , 12th ed., by Josephine A. Dolan, M.S., R.N. 380 pages. Toronto, W.B. Saunders, 1968.
Reviewed by Sister Madeleine, Director, School of Nursing, St. Joseph's General Hospital, Vegreville, Alta.

Teachers and students of history of nursing will welcome this book, which describes the evolution of the role of nursing in the history of mankind.

The text shows the course of nursing from primitive cultures to the present. Historical facts are enhanced with many interesting illustrations and diagrams. Throughout the book, emphasis is placed on the effect of the cultural, social, economic, technical, and spiritual forces affecting good nursing.

The last three chapters on nursing in the twentieth century contain up-to-date information on such topics as professional organizations for nurses, nursing education, evaluation of nursing, nursing in occupational health, maternal and child nursing, hospital social service, psychiatric nursing, and international relations. The author shows how the changing patterns of care of the sick and the refinement of nursing have been the result of the influence of wars, marked progress in transportation and communication, and remarkable inventions along with many scientific achievements. Such timely topics as medicare, aerospace nursing, Project Hope, and the Peace Corps are briefly discussed.

One other valuable asset of this book is the inclusion of a history of nursing in Canada.

This book would be most valuable in a course correlating history of nursing with professional adjustments.

Celiac Disease Recipes For Parents And Patients 2d. ed. 87 pages. Published by The Hospital for Sick Children, Toronto, 1968.
Reviewed by Shirley Pitt, Nursing Coordinator, Home Care Department, The Children's Hospital of Winnipeg, Manitoba.

This soft-cover recipe booklet contains an introduction by Dr. J. Hamilton. His informative summary of the ins and outs of celiac disease could be easily read and comprehended by the average parent. An earlier publication, *Celiac Disease: A Manual For Parents And Patients,* prepared by the staff at The Hospital for Sick Children, Toronto gives a more complete description of the disease and the principles of treatment. Dr. Hamilton suggests that parents contact their doctor to answer questions that are unanswered in these booklets.

The booklet's most commendable feature is that it integrates the child and the medical problem with the family set-up. Families who are attempting to cope with an ill child would benefit from more literature written along these same lines.

The list of allowed and not allowed foods is helpful, as is the sample meal plan. This page would be more useful if printed on separate tear-out cards, one for the food list, and one for the sample meal plan. The cards could be placed in a convenient place in the kitchen to be used for quick reference by parents.

The section headed "General Suggestions" presents a variety of helpful hints for mother to follow in the preparation of her child's diet. The information that glutin-free bread mix is available by mail from a Toronto firm is useful. However, no additional information is supplied regarding the availability of this item in other Canadian centers or its approximate cost, information of importance to parents in providing the glutin-free diet to their child.

The recipes are indexed for quick reference; throughout the recipes are helpful hints for easy preparation and storage.

This booklet is a useful aid for parents caring for a child with celiac disease. Pediatricians, pediatric nurses, and public health nurses should be knowledgeable of this book.

A Manual for Team Nursing developed by Mercy Hospital, Pittsburgh, Pennsylvania. 56 pages. St. Louis, The Catholic Hospital Association, 1968.
Reviewed by Sister Mary of Calvary, Director, Nursing Education, St. Michael's School of Nursing, Lethbridge, Alberta.

This manual on team nursing is methodically presented in four sections. Section 1 includes the history of team nursing, its philosophy, and some elaboration on "Why Team Nursing." The concept of team nursing is aptly described by the authors as a "plan which encourages the development of leadership, cooperation and conversation among all members of the health team and recognizes the individual worth more fully." It involves planning, working, learning, and conferring together, resulting in improved patient care.

The diagrams used portray vividly both the organizational set-up of traditional nursing with its task-oriented care and patient-centered team nursing.

Section 2 deals with the implementation of the team nursing pattern. This involves breaking down "resistance to change," a characteristic that invariably accompanies any effort to deviate from the traditional. The personnel comprising the team are outlined and the role and responsibility of each member is clearly delineated. Samples of team assignment forms are included. The team report and the team conference are part and parcel of the team concept. These serve to keep all members of the team properly informed of the objectives they are trying to achieve besides bringing about concerted effort on the part of all for more realistic patient-centered care.

The nursing care plan that results from the team conference is described as a brief word picture of the patient that portrays him as an individual. The plan serves as a guide for all the members of the team in carrying out patient care and helps in the effective utilization of nursing care hours.

A well selected list of 21 nursing problems is outlined in the manual for the guidance of persons caring for patients. These, hopefully, will be useful in helping to determine the individual needs and problems of the patients but should in no way take the place of observation and experience.

Section 3 presents with clarity 13 steps toward a successful team nursing program.

The last section contains an excellent and extensive bibliography.

In the material presented in this nursing team manual there is evidence of much thoughtful planning and forward thinking. A study of this manual would be invaluable to anyone who is contemplating replacing the traditional pattern of patient care with the nursing team concept.

Infection Control in the Hospital . 140 pages. Chicago, American Hospital Association, 1968.
Reviewed by Dorothy Pequegnat, Infection Control Officer, Ottawa Civic Hospital, Ottawa.

This book is a collection and evaluation of current useful information on the control of nosocomial infections. The authors recognize that each hospital varies from the others, and that the application of their recommendations therefore will vary, but that the principles presented apply generally to all hospitals.

If hospital facilities, practices, or procedures are at fault, the hospital can be sued for corporate negligence. Therefore, a hospital should at least adopt the minimal standards as recommended in this book by the American Hospital Association and the Joint Commission on Accreditation of Hospitals.

The book can be divided into three parts. The first section deals with the general organisation of hospital responsibilities. It provides guidelines for the establishment of an infection control committee, employee health service, education programs, and surveillance activi-

books

ties for the infection control nurse. Sample forms are also given for reporting of infections.

The second part of the book consists of specific responsibilities within the hospital: the individual responsibility of the administrator, physician, and nurses, and the departmental responsibilities of the microbiological laboratory, pharmacy, central supply service, food service department, laundry and linen service, as well as engineering and maintenance department.

The third part of the book deals with prevention and control of infection. The information includes architectural considerations with a sample isolation plan, microbial sampling programs, and, most important, isolation techniques and procedures. Special problems are also considered: those of infected personnel and carriers, hazardous areas such as the blood bank, the surgical suite, and the newborn nursery, and hazardous procedures such as inhalation therapy, tracheostomy, wound dressing, and catheterization.

This book is most timely; not only does it present the problem of infections in hospitals but provides helpful guidelines and recommendations to help establish a workable infection control program. It is a must for quick reference for all department heads concerned with the prevention and control of infections.

The Care & Feeding of Your Diabetic Child by Sally Vanderpoel. 116 pages. Toronto, Geroge J. McLeod, Ltd., 1968.

Reviewed by Joy Calkin, Lecturer, School of Nursing, The University of New Brunswick, Fredericton, N.B.

The author, a nutritionist and mother of a diabetic child for 10 years, has written this book for parents. It would be a valuable addition to a pediatric unit parents' library, a pediatrician's office, local community library, or nursing agency. However, its value is not limited to parents. Its practicality and its orientation toward helping the child and parents adapt to diabetes make the book valuable for anyone working with the child with diabetes.

Two concerns must be balanced by the parents of the diabetic child. How does the parent help the child to gain independence and self reliance, while at the same time observing and controlling "every phase of his life"? From her experience, the author describes certain procedures that are part of diabetic care. For example, she gives her son his injections when he is at home, and he gives them in her absence to "keep in practice." Her rationale is that by giving the injections in sites inaccessible for self-administration (such as the buttocks) she helps her son maintain the sites that he must use when he provides his own care in the years ahead.

Information and suggestions related to food exchange (included in the appendix), school lunches, travel, special occasions as birthdays, complications, involvement in sports and other activities, and the adolescent with diabetes are clear and reasonable. The author notes some of the problems she and her husband have encountered and what kinds of solutions they have used, and encourages parents to see what works best in their situation and family.

The brief history of diabetes mellitus and its treatment will help prevent some of the misunderstandings that occur about diabetes. Note is made of the direction of current research. The roles of the specialist and general practitioner are discussed in relation to their helpfulness to the child and parents.

The tone of the book is realistic, yet optimistic in relation to the "controlled" diabetic, and Mrs. Vanderpoel notes that there are advantages to the child and family in spite of the chronic disorder. She makes a plea for honesty, truth, and knowledge for the child – so necessary for adaptation to any chronic illness. Her conclusion notes "that human personal-

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ities grow by encountering a difficulty and mastering it . . . There is no need to compensate him for the things that he does not have or must do without. Given the opportunity to do so, he will compensate in his own wholesome way."

This book would be useful for parents and health workers who seek this as their goal of care.

Total Patient Care, Foundations and Practice, 2nd ed., by Dorothy F. Johnston, R.N., B.S., M.Ed. 526 pages. St. Louis, Mosby, 1968.
Reviewed by Iva J. Yeo, Instructor, St. Boniface School for Practical Nurses, Man.

The theme of this excellent textbook, as stated in the preface, is the patient as an individual, the constant need for the practical nurse to record and report, and the understanding on her part that she is a member of the nursing team. This second edition does not carry new chapters but has updated many of the original ones.

One chapter that has been rewritten deals with the patient with staphylococcal infections. In this chapter, the practical nurse is given an understanding of the sources of infection, clinical manifestations, nursing care, and prevention. Isolation technique, including medical and surgical asepsis, is not very detailed, but a good basis is established. More information regarding this is given in another chapter, which deals with communicable diseases. Because of the variation in individual hospital policy, further discussion is probably unnecessary.

In some areas, it might have been more beneficial to focus a little more narrowly. For example, much of the information in Chapter 11 under subtitles "Blood Products" and "Diagnostic Tests and Procedures" could have been omitted or less detailed. However, if the author's intent was to provide a one-book reference upon completion of the practical nurse's formal education, she may have felt it necessary to include the wider scope of technical information.

The text provides an extensive list of current references at the completion of each chapter plus a detailed glossary at the end of the book. Many well-identified illustrations, diagrams, and charts are of particular merit. As noted in the first edition, this textbook reflects changes in concepts, ideas and attitudes, not merely part of the evolutionary growth of nursing. It is a valuable addition to schools for practical nurses and, as stated before, as a reference for the licensed practical nurse working in areas such as smaller county hospitals, convalescent or nursing homes, or in private duty.

The Interview in Student Nurse Selection by C.H. Smeltzer, Ph.D. 185 pages. New York, G.P. Putnam's Sons, 1968. Canadian publisher: The Macmillan Company of Canada Ltd., Toronto.
Reviewd by Dorothy Syposz, Lecturer, School of Nursing, Lakehead University, Port Arthur, Ont.

This book is primarily directed to faculty members of diploma schools of nursing who are involved in interviewing applicants. Although the major concern is the interview as a tool in the selection of students, other elements of selection are also discussed to emphasize the necessary balance in criteria.

The topics covered include answers and information on almost all aspects of the interview such as: the importance of the interview in student selection, the choice of faculty as interviewers, the development of interview ability, common faults of interviewers, methods of interviewing, and the use of interview evaluation in selection.

The author states his belief at the beginning of the book that, if the interviewing phase of selection is properly conducted or can be improved, this part of the selection process will contribute to a reduction of the attrition rates. With the purpose of improving the technique of interviewing, the whole approach stresses the practical aspects rather than the theoretical. For instance, one chapter discusses methods such as individual, team, multiple interviewing, and types of interviews with lists of specific questions relating to the area to be explored, such as personal background, work experience, interest in nursing, and attitudes. Another chapter deals with the vital aspect of recording and consolidating interview summaries. Brief mention is made of various methods of recording, and the remainder of the chapter describes a graphic chart developed by the author and explains how this may be used. The last chapter outlines briefly 34 problems in interviewing candidates for entrance to a school of nursing; these merit research and study.

This practical book would be of value to any teacher of nursing who is interviewing prospective students, whether they are in a diploma or collegiate program, and to administrators who are concerned with the interview as a tool in student nurse selection.

Saunders Tests for Self Evaluation of Nursing Competence by Dee Ann Gillies, R.N., M.A., and Irene Barrett Alyn, R.N., M.S.N. 282 pages. Toronto, W.B. Saunders, 1968.
Reviewed by Dr. M. Josephine Flaherty, Assistant Professor, Department of Adult Education, The Ontario Institute for Studies in Education, Toronto, Ontario.

According to the authors, this book of tests of nursing competence is designed "both to instruct and to evaluate previous learning." Since the test items are comparable to those that nurses might encounter on licensure or graduate nurse achievement examinations, the authors intend the book to be of use to basic nursing students, graduate nurses, and nurse-teachers. They suggest also that nurses returning to practice after an absence of some years would find the book of value as a "narrative redefinition of a scene that has changed since their last view of it."

The text is divided into four major sections devoted to the following areas: maternity and gynecological nursing, pediatric nursing, medical-surgical nursing, and psychiatric nursing. Within each section there is further subdivision into disease-centered units where nursing situations are described and multiple-choice test items based on these situations are provided. A bibliography of books and articles related to the subject areas being tested is provided for each of the major sections of the book.

Although the title of this book mentions evaluation of nursing competence, no attempt is made by the authors to explain exactly what is meant by nursing competence. It is presumed, however, that the tests in this book, nursing licensure examinations, and graduate nurse achievement examinations share a similar aim: to assess a candidate's ability to use nursing knowledge in making decisions that result in safe nursing practice. Judgments about whether tests are appropriate for use in particular situations are based on assessments of the characteristics – such as validity, difficulty and so forth – of the tests. The validity of any set of test items can be determined only in terms of a well-defined set of objectives describing the behaviors being measured, and with reference to a population that has been identified. The authors mention that items in each section vary considerably in difficulty so that the abilities of both undergraduate nursing students and graduate nurses can be tested; however, no attempt is made to define the specific nursing behaviors that are expected of the different groups of examinees. Hence, users of this book may find it difficult to identify appropriate test items and make meaningful evaluations of nursing competence based on the given tests.

The usefulness of this book for nursing students or graduate nurses who wish to refresh their nursing knowledge is questionable. Although correct answers

are given for all items, the answers are without explanation and some could probably be debated. There is danger that persons using this book might accept given answers without understanding them fully. Had the authors provided for students a clear explanation of the use of the test items as a means of identifying weaknesses and gaps in knowledge, and made specific suggestions for remedial work, the book might have been more useful.

Similarly, graduate nurses wishing to refresh their nursing skills would likely have difficulty understanding the nature of changes in nursing without considerably more detail than that provided in this book. Hopefully, both students and graduates would make use of the bibliographies provided, but more direction would probably be required.

While nurse-teachers might find the book of some value as a source of ideas for teaching and testing, they would have to make careful assessments of the suitability of the situations and items for their particular settings; hence teachers' use of the book is likely to be somewhat restricted.

On the whole, this book seems to have limited value as an instrument for self-evaluation of nursing competence and is not recommended for libraries in schools of nursing.

A Unified Health Service by David Owen, Bernie Spain, and Nigel Weaver. Edited by Dr. David Owen, M.P. 148 pages. Toronto, Pergamon of Canada Ltd., 1968.

Reviewed by Sheila Rymer, Health Educator, Department of National Health and Welfare, Ottawa.

This book was coauthored by David Owen, a doctor who is a member of the British Parliament; Nigel Weaver, a hospital administrator; and Bernie Spain, a research worker in social and community studies in London, England.

The chapter headings indicate that the authors intend to describe the evolution of Britain's National Health Service, its present structure, the place of the general practitioner, and the failure of the tripartite administration to provide a workable, coordinated health service. Proposals are made for organization of a unified health service, management and administration of Area Health Boards, the general practitioner and community services, mental health services, and welfare services. The appendix includes tables of statistics and case histories.

Unfortunately for the reader unfamiliar with British terminology, the authors lapse into an alphabetical soup. If the National Health Service is as confusing as the book, it is a wonder patients get any care at all.

Apparently the Service is organized under three different administrations: 1. hospitals and specialist services; 2. local Health Authority services responsible for prevention of illness, home nursing, midwifery etc., and 3. Executive Council Services, responsible for general practitioners, dental practitioners, ophthamologists, opticians, and chemists. Each of these services has administrative units at the local level and evidently no two have the same boundary lines. This means that a doctor discharging a patient from hospital and wishing to have him followed at home has to know which office of the Health Authority Service to call for each of the districts in which he practices. It means that there is no administrative means for the specialist who has given the patient hospital care to communicate with the general practitioner, much less a home visitor nurse who might be looking after the patient at home. It means that there is no means (in fact there are obstacles) for interservice planning of programs or facilities.

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those involved in planning community health services in that it gives considerable emphasis to the need for communication among the growing numbers of health specialists and organizations.

Infectious Diseases, 5th ed., by A.B. Christie, M.A., M.D., D.P.H., D.C.H. 371 pages. London, Faber and Faber, 1968.
Reviewed by Dr. D.W. Menzies, M.B., Ch.B., Ph.D., M.C.P.A., Medical Officer in Charge, Field Study Unit, Epidemiology Division, Department of National Health and Welfare, Ottawa.

Since the time that this well-known and useful text for nurses was first published revolutionary changes have occurred in the treatment of infectious disease. Tuberculous meningitis is no longer fatal, poliomyelitis has been reduced to an item on a printed page, and clinical diphtheria is becoming more and more a rarity.

Condensing all this new knowledge into a simple and readable style, combined with accuracy, is no mean feat. On the whole the book does this well. The section on hospital sepsis is a good example of the author at his best.

Some sections do, however, require further revision. The discussion on infectious hepatitis specifies an incubation period – 25 to 35 days – which would cause some eyebrows to rise. Usually, two to six weeks is quoted. The incubation period of serum hepatitis is somewhat vaguely described as about 100 days. Eight to 22 weeks is more in accord with current thinking. A recommendation is made to isolate the jaundiced patient at home, in spite of the known probability that other family members would already be affected. The section on tetanus prophylaxis requires some updating; its recommendations relating to antitoxin are unfortunately imprecise. Illustrations no. 8, 9, 10, and 11 should be reconsidered. They are not up to the general standard of the book. It is also worth noting, in the section about venereal disease, that the "promiscuous" person is not necessary unstable and immature, as the author implies. Not only the psychologically sick, but the apparently normal individual contributes to the venereal disease problem.

In spite of these minor blemishes, the book does what it sets out to do and its continuing popularity is a measure of its value. Nurses, health visitors, public health inspectors, and student teachers will find it very useful for reference purposes.

Health Services Administration: Policy Cases and the Case Method edited by Roy Penchansky D.B.A. Cambridge, Harvard University Press, 1968.
Reviewed by Frances Howard, Consultant Nursing Service, Canadian Nurses' Association, Ottawa.

The editor's words in the preface of this volume document the value of this text as a reference text for both educators and practicing administrators, whatever their area of management might be: "It is . . . my belief that to develop skills in the administrative processes it is necessary to employ a teaching technique that provides the student with guided experience in such processes and, further, that the case method of teaching . . . is one of the most useful of such teaching techniques."

The volume contains 12 case studies describing real-life events that have occurred not only in the western hemisphere but also in other parts of the world. These case studies have an added advantage in that they provide historical references not easily obtained from other sources. In addition, there are specific papers illustrating the use of the case method in the education of health service administration personnel. □

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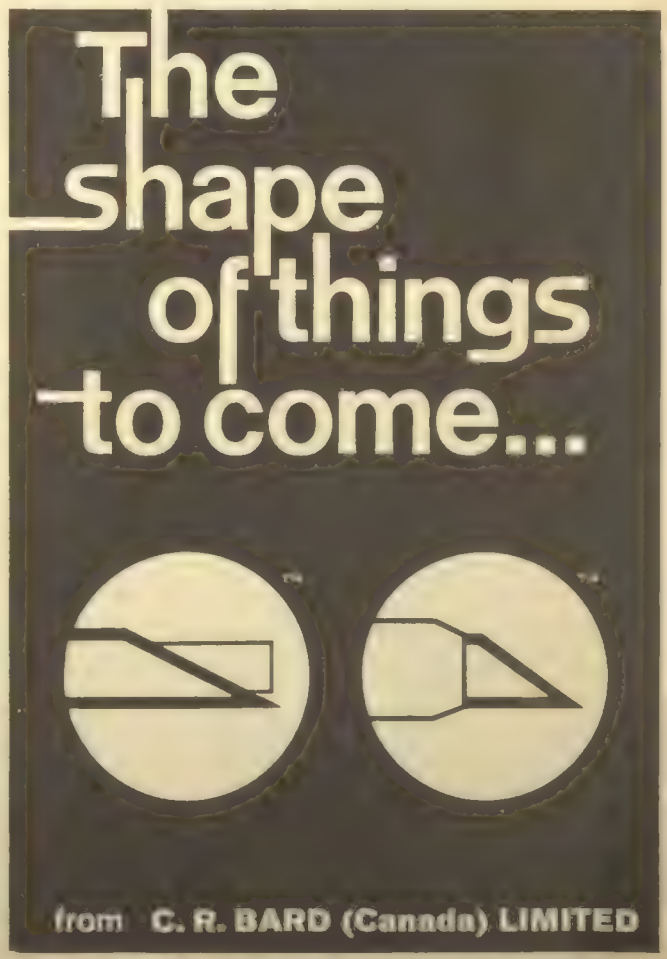
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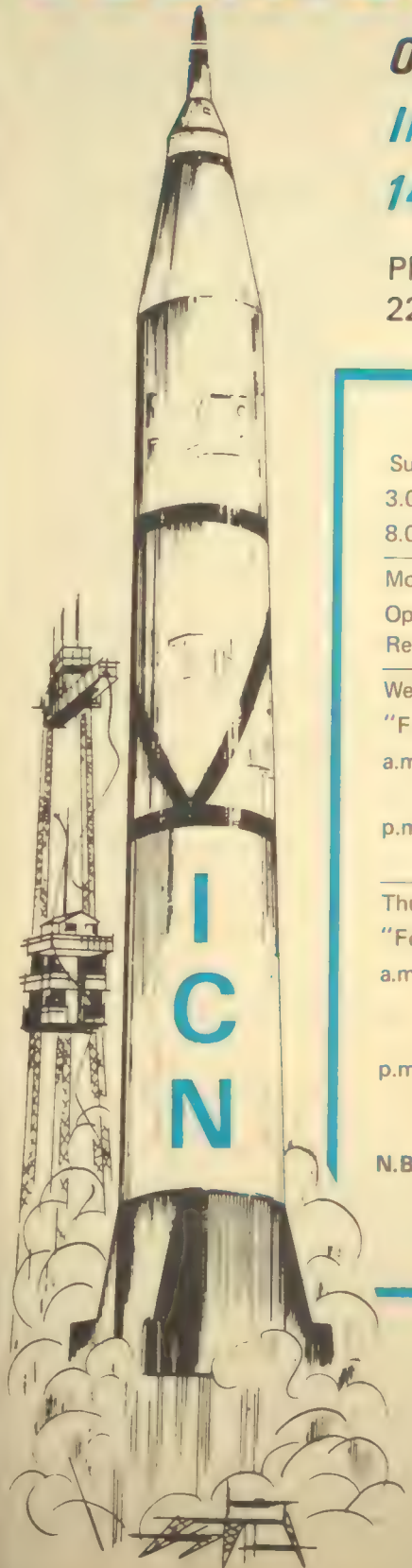
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Editorial

The fact that the Canadian Nurses' Foundation is still light on cash is not really news. Ever since the five-year grant from the W.K. Kellogg Foundation ended in 1967, CNF has had its back to the wall.

There are at least three reasons for CNF's present financial plight: first, many nurses — particularly those who are presently inactive in nursing — are unaware of the existence of the Foundation; second, too many nurses who know about CNF are unconvinced of its importance and do not bother to join; third, the present membership fee of $2 is not enough to cover even the secretarial and mailing costs (now paid by the Canadian Nurses' Association).

As we see it, the first two causes of CNF's predicament must be tackled by an intensive, coordinated public relations program on a national and provincial basis. The paltry number of members (1,494 at present) is clear proof that a haphazard approach to publicity just does not work.

The answer to the third reason for CNF's present dilemma is obvious: raise the fee to at least $5. When nurses become aware of CNF and its importance to the profession, they will not object to paying an additional $3.

The incoming CNF Board of Directors will no doubt be encouraged by the recent announcement that a third provincial nurses' association has now pledged annual donations to the Foundation. We hope, however, that the Board will recognize the need to get the Foundation's message across to *all* nurses, and will appoint one or more of its members to be responsible for an aggressive PR program.

— V.A.L.

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

A new nursing publication

To increase communication among faculties of Canadian university schools of nursing, the staff of the School for Graduate Nurses, McGill University, has decided to sponsor a small newspaper to provide a medium for assessing problems, posing questions, and describing ideas and plans of action by persons concerned with university preparation and nursing research.

We invite all faculty to contribute articles, but also to respond in critical fashion to the ideas presented in the proposed paper. In other words, some will put forth their views, while others will respond with considered and thoughtful commentary to provide dialogue on the problems and ideas therein.

We plan three issues of the publication in 1969. The format, presentation, and distribution of the paper will be simple; however, the mailing list will include schools and agencies other than those classified as university. The School for Graduate Nurses will finance the first issue, but looks forward to contributions for subsequent publications. Please address all inquiries to: Nursing Publication, School for Graduate Nurses, McGill University, 3506 University Street, Montreal 112, Quebec. – Moyra Allen, Associate Professor of Nursing, McGill University, Montreal

Is nursing really going forward?

It was with great interest that I read Dr. H.K. Mussallem's article "The Changing Role Of The Nurse" in the November 1968 issue of THE CANADIAN NURSE.

Although it was interesting and contained a lot of forecasting, I disagree in part with the author. The following sentence puzzles me:

"This may mean that in the next decade the practice of nursing could more closely resemble the practice of today's 'family doctor' than of today's nurse."

A patient, who practically or theoretically depends on nurses for his physical, physiological, emotional, social, and psychological needs, can walk into any drug store at any time of the day and buy himself a pain reliever, such as Aspirin, a laxative, or an antacid. Yet a nurse is not allowed to use his or her imagination, knowledge, and experience to give an Aspirin when a patient has a headache, a laxative when constipated, or an antacid when indigestion is present. How on earth is this nurse going to resemble a family doctor 10 years from now? I am taking for granted that the nurse can make sure that the patient does not have a gastric ulcer, or is not allergic to Aspirin, has not had a surgical intervention on his alimentary tract or other contraindications.

Dr. Mussallem goes on to say: "If certain trends continue, nurses could become medical technicians, not nurses." I think that this is already the case. With the number of changes that are taking place, it will certainly not be surprising if someday one can become a nurse by taking correspondence courses. Nursing is becoming more and more theoretical because many nursing experts have left the hospital setting and disassociated themselves completely from patients. They build beautiful theories for the benefit of nurses, and leave the patients to nonprofessionals. Some experts have spent more time accumulating degrees than practicing nursing.

Hospital schools of nursing in Canada are full of instructors who obtained a nursing diploma, then rushed to the nearest university for a degree – thus buying themselves a passport to teach. Does three months training as a student on a medical, surgical, obstetrical, or psychiatric unit qualify any nurse to teach future graduate nurses? Is that not putting the cart before the horse? Some nursing instructors have never been in charge even for a few hours.

I have known nurses from universities and nurses from diploma schools. Give me anytime nurses from diploma schools. I do not want theory; I want – rather the patient wants – practice.

Has anybody come across the situation when a nurse who has developed a good primary relation with a patient suddenly loses the confidence of that patient when she very clumsily performs a nursing procedure or applies a dressing? Has anyone heard a patient say: "Nurse X is ill-mannered or rude, but boy does she know her stuff."

Where are we going to draw the line? We want nurses with little practical experience, but with a degree, to teach and make good practical nurses. Isn't our logic faulty? – M.H. Rajabally, S.R.N., R.M.N., Ottawa.

The patient — another professional

The article by Carlotta Hacker in the January issue entitled "A New Category of Health Worker for Canada? " provoked me to raise questions.

The question of where this worker will stand in the hierarchy of hospital organization seems, to Mlles Provost and Desjardins, to be of little concern. To quote: "They look neutrally on the suggestion, seeing the assistant as being neither superior nor inferior to the nurse."

I submit that neutrality will be nonexistent. The doctor's assistant will almost immediately become superior to the nurses issuing orders for treatment and tests.

The second question is a crucial one. This article is well-written, provocative, and includes many professional opinions. But I would suggest that one "professional" has been overlooked – the patient. He pays a phenomenal sum for health services and he is quite sophisticated and professional in his demands. Why not ask him what he thinks of another category of health worker? – A. Joyce Bailey, Reg.N., Toronto, Ont.

Sacrifice to specialization

I am writing with regard to the article "A New Category of Health Worker for Canada? " published in the January issue.

"Every stage in transition leading to the industrial state has been marked by a sacrifice to specialization. Every step has moved man away from complete personal involvement in the task at hand; instead he usually specializes in a part of it," Say Rogg and D'Alonzo in *Emotions and the Job.* Although the above quotation deals with industry, it can be applied without revision to the medical and paramedical professions.

Granted, the explosion of knowledge makes it impossible for any one man to possess all knowledge or, in the medical profession, take complete responsibility for all aspects of a patient's care. However, some of the major problems in patient care today stem from the fact that there are too many categories of workers attempting to give care to the patient.

I take particular exception to the terms used by Dr. McKendry in the article: "It is demeaning for them [doctors] to be doing these tasks." This is where many of the ills of nursing have begun. We have assigned so-called less important tasks to auxiliary personnel so that nurses could be freed for apparently more important duties. This has resulted in the professional nurse sometimes being furthest away from patient contact. It i



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letters

hard to believe that doctors now wish to put themselves into this dilemma.

The creation of a new medical worker raises a number of questions:

1. Where will the line be divided between unique functions of the doctor and those of his assistant?
2. Could not medical technologists be trained in some of the functions the doctor wishes performed by this new medical assistant?
3. What will be the relationship between the medical assistant and the nurse caring for the patient?
4. How will the doctor and nurse, who would be even further separated by this medical assistant, communicate?
5. What or who would prevent a doctor from hiring more than one medical assistant?

With medicine now looking toward family practice and team medicine and toward concepts of treatment centers where all facilities will be available to members of a community who need them, it is hoped that the notion of a new medical worker will be abandoned and that doctors, certainly aware of the necessity of human contact, will attempt to get closer to their patients, not further away from them. – Alberta Casey, Lecturer, Psychiatric Nursing, Ottawa.

Smoking nurses

In recent months I was ill in two different hospitals. In the large hospital I was impressed with the high calibre of the nursing service, and the kindness manifested by the staff. One is aware that true nursing takes into consideration the whole person. It is not merely making beds and bringing pills at stated intervals.

Perhaps by coincidence, I saw no evidence of nurses smoking in the large hospital, but considerable evidence in the smaller hospital. Nurses are human beings, subject to the same human frailties as other members of society, but we think of all members of the medical profession as "working together for health."

Much has been said recently about the hazards of cigarette smoking, and much more should be said about alcohol as a health, social, and safety problem.

Is it not true that nurses should be paying more attention to the Florence Nightingale Pledge to which every nurse on graduation solemnly subscribes: "I will abstain from whatever is deleterious . . . I will do all in my power to maintain and elevate the standards of my profession." – Kate E. Watson, Vancouver. □

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news

Journals' Postal Problems Discussed By CNA Board

Ottawa. — The two journals of the Canadian Nurses' Association, *L'infirmière canadienne* and *The Canadian Nurse,* will continue to be published in their present form, at least until the next Board of Directors meeting in November, even if the money has to be borrowed to pay the increased postal rates that come into effect April 1. This decision was made by the CNA Board after members had discussed in detail possible ways to modify the present form of the journals.

One suggestion, that the journals be published every second month instead of every month, was rejected when it was explained that the information in the "News" section would be outdated in a bimonthly publication, and that considerable advertising revenue would be lost.

A motion to investigate the cost of publishing and mailing one bilingual journal in the two languages (in the form of a "flip" journal – French material at one end, English material at the other end) was withdrawn. The CNA general manager, Ernest Van Raalte, pointed out that the extra mailing and printing costs of a single bilingual journal of 104 pages sent to each member would amount to an extra $14,921 on top of the $135,000 increase in mailing rates.

The CNA Board will discuss this financial problem again at its November 1969 meeting.

CNA Sets 1970 Salary Goals: $7,200 for Diploma Nurses, $8,460 for University Grads

Ottawa. — The national salary goal for 1970, approved by the Canadian Nurses' Association's Board of Directors at its meeting February 11-14, aims to close the gap between starting salaries for registered nurses and starting salaries for other professional workers in the country.

The salary goal, as recommended by the Committee on Social and Economic Welfare, would give the beginning practitioner of a basic diploma nursing program "no less than $7,200 per annum," and the beginning practitioner of a baccalaureate program "no less than $8,640 per annum." The 1969 national salary goal, which was approved by the CNA general membership at the biennial meeting in 1968, recommended that the diploma graduate get $6,000 as a starting salary, and that the baccalaureate graduate get a salary "substantially greater."

In explaining her committee's decision to recommend these increased salary goals to the Board, chairman Louise Tod said that a careful review of salaries paid to members of comparable professions in Canada had been made by the committee. "We found that persons in other professions, such as teaching, were still being paid higher starting salaries than nurses," Miss Tod said. "As a matter of fact," she added, "the salaries paid to nursing orderlies in some provinces were very close to those being paid to nurses in 1968."

Miss Tod pointed out that a 1967 survey conducted by the Department of Manpower and Immigration showed that starting salaries of nurses with university education were at the bottom of the list of 55 named professions. "If we are to attract suitable persons into nursing and retain them, we must bring nurses' salaries in line with those of other professionals," she said.

Other policies recommended by the Committee on Social and Economic Welfare and approved by the Board are:

- That in the interest of quality patient care, social recognition and economic reward should be given those nurses who become expert nurse practitioners.
- That the CNA recommend to provincial nurses' associations that management nurses be encouraged to utilize existing legislation or, if necessary, that the provincial organization seek further legislation or alternate methods to represent effectively nurses whose function is deemed to be managerial.
- That the Board of Directors initiate a study of all federal legislation that has implications for nursing and nurses, and any necessary action be implemented to effect changes.

These revised goals on Salary and Employment Standards, along with new Social Welfare Goals approved by the Board, are to be published as a separate document in 1969, and will be available on request to all CNA members.

The Social and Economic Welfare Committee, which held one meeting in the 1968-70 biennium, will meet again in Ottawa early in 1970, with the employment relations officers of the provincial associations.

Orientation Day for New Board Members



An orientation day for new members of the Canadian Nurses' Association Board of Directors and provincial executive secretaries was held prior to the Board meeting February 11-14, 1969. M. Geneva Purcell (left), president of the Alberta Association of Registered Nurses, and Irene Leckie (center), president of the New Brunswick Association of Registered Nurses, are shown with Lois Graham-Cumming, director of CNA's Research and Advisory Services.

news

CNA Testing Service To Be Located In Ottawa

Ottawa. —The Canadian Nurses' Association Testing Service will be located in Ottawa. This decision, based on a recommendation of the CNA Executive Committee, which had investigated physical facilities for the Service in Ottawa, was approved by the CNA Board of Directors at its meeting February 11-14, 1969.

CNA becomes the official owner of the testing service May 1, 1970, when it takes over the existing testing service of the Registered Nurses' Association of Ontario. At present, a liaison committee, composed of the 10 provincial registrars, is working closely with the director of the RNAO Testing Service, Dr. Dorothy Colquhoun, to facilitate present planning for test development.

The CNA Board considered whether the new national testing service should be incorporated, that is, have its own Letters Patent and be set up as an independent body similar to the Canadian Nurses' Foundation, or whether it should be under the control of the CNA Board of Directors. Board members agreed that the testing service should eventually be set up under an independent board.

The CNA Board agreed to defer the final decision until its meeting November 3-7, 1969, at which time Board members will be asked to discuss the terms of reference for a provisional board.

Considerable discussion centered on the need to give instruction in item writing and test construction to nurse educators throughout the country. The Board agreed that this responsibility rested primarily with the provinces, and that CNA would set up self-supporting workshops only if necessary.

Special CNA Meeting To Be Held This Year To Consider Bylaws

Ottawa. —A Special Meeting of the Canadian Nurses' Association will be held sometime during the week of November 3, 1969, to consider amendments to the Association's bylaws.

This decision was made by the CNA Board of Directors at its meeting February 11-14, after Board members expressed concern about any further delay in obtaining the issuance of Letters Patent for the Association under the Canada Corporations' Act. Without this special general meeting, CNA would have to wait until the regular general meeting in June 1970 to have the bylaws approved by membership.

The approval of bylaws will be the only item considered at the special general meeting in November. Each province will be entitled to a number of votes based on membership, and will assign these votes to one or more delegates.

Board members were brought up-to-date on CNA's progress in applying for Letters Patent under the Canada Corporations' Act by Gordon F. Henderson, Q.C., legal adviser for CNA. Mr. Henderson said that it is the Association's obligation now to satisfy the Department of Consumer and Corporate Affairs that the CNA bylaws comply with the requirements of Letters Patent companies.

"The one item that constitutes a change of some substance," Mr. Henderson said, "is the change dealing with withdrawal from membership in the Association. At present," he added, "the corporate structure of CNA is worded in such a way that the provinces named are members, and there is no provision for withdrawal for member associations. This bylaw on withdrawal must be added," he explained, "to comply with the Canada Corporations' Act's requirements for Letters Patent companies."

Other bylaw amendments of a more formal nature will also be required, Mr. Henderson said.

A copy of the old bylaws and the proposed bylaws will be sent to the provincial nurses' associations in mid-April for study by their legislative and bylaw committees. The final draft of the bylaws will be sent to the provincial associations at least two months ahead of the special general meeting in November.

Board Approves Revised Continuing Education Statement

Ottawa. —The revised statement on continuing education prepared by the Committees on Nursing Education and Nursing Service of the Canadian Nurses' Association was accepted by the CNA Board at its meeting February 11-14.

The original statement had been referred back to the committees for restatement and clarification by the CNA Gen-

(Continued on page 10)

UBC Celebrates Golden Jubilee



Vancouver. —The University of British Columbia honored the Golden Jubilee of its School of Nursing and the memory of its first nurse director, the late Ethel Johns, LL.D., on January 12 at a ceremony presided over by UBC Chancellor John M. Buchanan. Elizabeth McCann, acting director of the School of Nursing, paid tribute to the School's first three directors, Ethel Johns, Mabel F. Gray, and H. Evelyn Mallory, and described the growth of the school from its first three students in 1919 to its present graduating class of 97.

Dr. Rae Chittick, professor emeritus, McGill University, delivered a tribute to Miss Johns, before Professor Margaret Street (left), presented a collection of medals and medallions to Basil Stuart-Stubbs (right), University librarian. The medals and medallions were Miss Johns' gift to the Charles Woodward Memorial Room. The ceremony was attended by representatives of the faculty and Nursing Undergraduate Society, and hospitals and organizations from Vancouver. A reception was held afterward, and exhibits prepared by the library staff were viewed.



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(Continued from page 8)

eral Meeting of July 1968. The revised statement will appear in a future issue of *The Canadian Nurse.*

The Board also agreed to a recommendation from the Nursing Service Committee that CNA's Social and Economic Welfare Committee be asked to consider: what social or financial recognition could be given to nurses giving excellent performance versus those giving average performance; and ways to maintain standards of care when collective bargaining agreements are drawn up.

The Committee met at CNA House January 14 to 16 under the chairmanship of Margaret McLean.

Board Approves Nursing Education Motions

Ottawa. – The Board of Directors of the Canadian Nurses' Association will make efforts to initiate dialogue between the allied health professions on the question of proliferation of categories of health workers, with a view to formulating a policy statement.

This decision was taken on a recommendation by CNA's Committee on Nursing Education, made at the Board meeting February 11 to 14. The Board also agreed to the following motions made by the Committee:

- The regulation of entry into the nursing profession, including approval of basic nursing programs, *must* rest with the legally constituted professional nursing body in each province. This move was felt necessary since diploma schools of nursing are moving into the general educational stream, and concern has been expressed as to whom has the legal authority to approve programs in these cases.
- Since some activities of non-nursing personnel affect the welfare of those receiving nursing care, nurses should collaborate in educational programs for such workers.
- Those students studying nursing in university programs should receive priority in the use of hospital and health agency experience until CNA's recommended ratio of two categories of nurse practitioners is reached. This ratio is one graduate of a baccalaureate program in nursing for every three diploma program graduates. At present, some 94 percent of working nurses in Canada hold diplomas; the remaining six percent have degrees.

The Nursing Education Committee met prior to the Board meeting, January 21-23, under the chairmanship of Kathleen Arpin.

Official Opening Of MARN Headquarters



Winnipeg. – Manitoba Lieutenant Governor Richard S. Bowles officially opened the new headquarters of the Manitoba Association of Registered Nurses January 17. Some 80 official guests watched as Lillian Pettigrew, associate executive director, Canadian Nurses' Association, unveiled a cornerstone marking the occasion. Miss Pettigrew is seen above (right) with Dorothy Dick, MARN president.

Miss Pettigrew, for many years MARN executive secretary, said, "This fine building identifies the vitality of the profession in Manitoba and bears testimony to the faith of nurses in the permanence of their services. May the facilities of this handsome headquarters inspire their efforts and assure their success."

Items of historical interest to nursing were placed behind the cornerstone, to be opened in 100 years. Included were biographical sketches of MARN's honorary members.

Greetings were extended by Alderman Inez Trueman, from the City of Winnipeg; Thomas B. Findlay, Counsellor of the Metropolitan Corporation of Greater Winnipeg; Dr. R.H. Tavener, from the provincial health ministry; and Labour Minister C.H. Witney, representing Manitoba Premier Walter Weir.

Mailing Charges Both Ways On CNA Library Loans

Ottawa. –As a result of increased postal rates, the Canadian Nurses' Association's library will now require all borrowers to pay mail charges both ways. The decision was made by the Board of Directors at its meeting February 11-14, 1969 and will be effective April 1, 1969.

Payment of mailing charges both ways has always been a requirement under the formal inter-library loan agreement. This requirement has not previously been extended to individual or institutional borrowers who do not use the standard inter-library loan forms. Now, in addition to paying the return postage, all borrowers will be expected to refund, in postage, the cost of mailing library material to them.

Draft Standards To Be Tested

Ottawa. –The present draft standards drawn up by the Ad Hoc Committee on Standards for Nursing Service of the Canadian Nurses' Association will be tested in selected areas before final revision.

CNA Board of Directors, meeting February 11 to 14, agreed to a plan for testing these standards laid out in a progress report by Committee Chairman Irene Buchan: approval of areas selected for testing will be sought; draft standards will be forwarded; and each committee member will be assigned to a particular area for necessary discussion.

Purpose of the testing is to determine whether these standards are concise, applicable, reliable, etc. Comments from testing areas will be used in the final revision.

The draft standards are in the form of a self-evaluation guide, since the final standards are planned as a tool for use by nursing administrators in all nursing services in evaluating and improving the quality of nursing service.

(Continued on page 12)



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news

(Continued from page 10)

This guide will include areas on: philosophy; objectives; functional structure of the nursing department; personnel, material resources; and the nursing department within the total organization.

CNF Elects New Board, Ponders Financial Problem

Ottawa. —Members at the annual meeting of the Canadian Nurses' Foundation elected a new Board of Directors to serve a two-year term — then briefly reviewed some of the problems that the new Board will have to face.

Elected to the Board were: Jean Church, Dorothy Dick, E. Louise Miner, M. Geneva Purcell, and Albert W. Wedgery from the Board of Directors of the Canadian Nurses' Association; and Alice Beattie, Sister Marie Bonin, Hester J. Kernan, and Marion C. Woodside from the membership-at-large. The new president and vice-president will be elected from the board at its first meeting.

Few solutions were proposed for the Foundation's financial ills. This year, members had to vote to transfer $10,000 from the general membership fund into the scholarship fund to provide at least $25,000 for awards. This is about one-half the amount awarded in 1967 or 1968.

"Any moneys raised before awards are given in May would, of course, be added to the funds," retiring president M. Jean Anderson reported.

Other suggestions to promote interest in CNF and to raise money were discussed during the meeting and will be taken to the Board for decision.

Members approved a suggestion from the retiring Board that baccalaureate awards again be deferred (for 1969-70) as funds are so low.

One member suggested that CNF should plan more and better promotion and publicity campaigns. Miss Anderson reviewed what had been done during the past year and added that she hoped that the provinces would undertake more responsibility in this area. Miss Anderson added that the Board is considering a promotion campaign to let nurses know how they may leave money to the Foundation in their wills. "We believe that many nurses do not know that they can do this, or know how to go about it," she said.

A suggestion that the CNF meeting be held concurrently with the CNA meeting was made by one member-at-large. She added that this might promote more interest among nurses. This year's annual meeting was held February 11 during the week of the CNA Board meeting so that representation from all provinces would be assured. About 35 of the 1,494 members attended. Only 16 members had attended the previous annual meeting.

A suggestion that membership fees be raised from $2 to $5 was discussed and several members suggested it would not be feasible at this time. "We need a large volume of members — and we'll never attract them by raising the fees," was one comment.

The new Board will meet within the next few weeks to consider these matters.

ANPQ Donates $50,000 To ICN Congress

Montreal.—A gift of $50,000 has been donated by the Association of Nurses of the Province of Quebec to the XIV Quadrennial Congress of the International Council of Nurses, to be held June 22-28 in Montreal.

The decision to donate the money was made by the Committee of Management of the ANPQ in October, 1968, but the gift was not announced until mid-January when the cheque was received by Helen K. Mussallem, executive director of the Canadian Nurses' Association. According to Helena F. Reimer, secretary-registrar of the ANPQ, the gift was made for four reasons: the heavy costs of the ICN Congress; the fact that the ICN president, Alice Girard, is a member of the ANPQ, and that the Congress is to be held in Montreal; and because the ANPQ is a member of the CNA.

Dr. Mussallem thanked the ANPQ for the donation, commenting, "This tangible evidence of support is heartwarming to those who bear the responsibility for the execution and financing of the large international convention."

ICN Registration Deadline Extended To March 31

Ottawa.—The deadline for the $40 registration fee for the 14th Quadrennial Congress of the International Council of Nurses has been extended to March 31 from January 22, according to Harriet J.T. Sloan, ICN Congress Coordinator.

The extension of the deadline is due to delays in transmittal and processing of registration forms, Miss Sloan said. The fee for registration after March 31 will be $60.

The completed registration, together *with the necessary money,* must be received at CNA House, 50 The Driveway, Ottawa 4, by March 31 to qualify for this advance fee.

The completed registration, together *with the necessary money,* must be received at CNA House, 50 The Driveway, Ottawa 4, by March 31 to qualify for this advance fee.

Curriculum Conferences Held in Vancouver and Victoria

Ottawa.—Two conferences on curriculum construction, sponsored by the Registered Nurses' Association of British Columbia, were conducted last month by Shirley R. Good, consultant in higher education, Canadian Nurses' Association. The first was held in Vancouver February 3 and 4, and the second in Victoria, February 6 and 7.

"The request from RNABC was for a conference dealing with curriculum as it relates to concepts and principles," Dr. Good told *The Canadian Nurse.* To deal with this question, Dr. Good compared the construction of curricula to construction of buildings, and divided her theme "Highrise for Curricula" into five sections.

The first section, "selection of site," considered the question of how a person thinks, and the thought process. Critical thinking was dealt with in the second section, "concrete foundations." "Tools of the trade" differentiated between concepts and principles, and "windsway factor" dealt with concepts, definitions, and statements of concepts. The final section, "staircases," considered the design of a nursing curriculum based on these ideas.

Throughout the conference, participants divided into small groups to consider vignettes presented for discussion. They were asked to identify nursing knowledge, the principles inherent in the knowledge, and the basis for nursing judgment and action.

Participants included instructors of nursing assistants and psychiatric nurses, as well as instructors in diploma and university schools of nursing.

ICN Registration Triples

Ottawa. —Canadian registration for the Congress of the International Council of Nurses to be held in Montreal has almost tripled since January 10, 1969. As of February 10, 2,145 Canadians had registered for the June 1969 Congress, nearly 1,400 more than one month earlier. On January 10, Harriet J.T. Sloan, ICN Congress Coordinator, reported that 756 Canadians had registered for the international meeting.

Breakdown of registration up to February 10, 1969 is:

British Columbia	98
Alberta	126
Saskatchewan	38
Manitoba	68
Ontario	693
Quebec	802
Nova Scotia	53
New Brunswick	107
Prince Edward Island	13
Newfoundland	10
	2,008
Students	137
Total	2,145

Alberta And British Columbia Announce Contributions To ICN

Ottawa. —The Alberta Association of Registered Nurses and the Registered Nurses' Association of British Columbia recently announced contributions to the International Council of Nurses XIV Quadrennial Congress to be held in Montreal June 22-28.

The AARN will donate $7,000 and the services of its public relations officer, Donald LaBelle, for the duration of the Congress. The Association is also planning a hospitality luncheon at which AARN members will entertain a representative of each international association attending the Congress. The provincial council of AARN is providing funds to district executives to assist in defraying costs of members attending the Congress.

The RNABC will also donate the services of its public relations officer, N. Fieldhouse, for the Congress, and $5,000 toward the cost of holding the Congress. The Association will pay the living expenses of RNABC staff at the Congress, and of six nurse hostesses from BC. It will also donate 12,000 Canadian flags and a number of copies of the publication *Beautiful BC.* Another $500 will be donated to provide music for the Congress.

SRNA Announces Annual CNF Donation

Ottawa. —The Saskatchewan Registered Nurses' Association recently announced that a contribution of $1. per member will be given annually to the Canadian Nurses' Foundation, commencing this year.

This brings to three the number of provincial nurses' associations that have pledged annual contributions to CNF: the Registered Nurses' Association of British Columbia, the Alberta Association of Registered Nurses, and SRNA.

At the CNF annual general meeting February 11 in Ottawa, president M. Jean Anderson noted that small group donations from Alberta, British Columbia, and Saskatchewan have increased in number, probably because nurses in these provinces are more aware of the Foundation's needs.

Special Sessions For ICN Congress Registrants

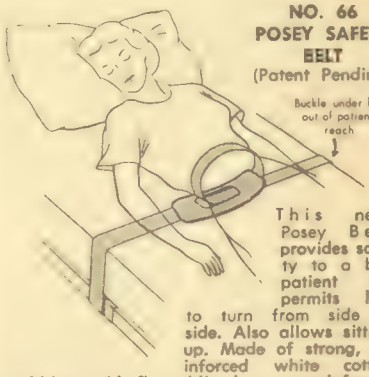
Ottawa. — Nineteen special interest and clinical sessions will be presented during the 14th Quadrennial Congress of the International Council of Nurses in Montreal, June 22-28, 1969. According to ICN Congress Coordinator Harriet J. T.

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Sloan, most of the 19 sessions will be presented in English and French beginning Monday June 23 and ending June 27.

Topics for the special interest sessions include: leadership and management; use of computers in nursing service administration; audiovisual media in nursing education; the printed word (learning the writer's skills); nursing journalism; libraries in schools of nursing and for professional associations; forming and developing the national association; nursing legislation; and nursing research.

Topics for the clinical sessions include: continuity of patient care; nurses and the practice of nursing; psychiatric and mental health nursing; implications for nursing practice for patients with heart surgery; outpost nursing; implications for nursing practice with patients with renal transplantations; occupational health; emergency health preparedness; rehabilitation; and space age nursing.



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NBARN Presidents' Conference

Fredericton.—"The Chapter Chain – Improvement Through Involvement" was the theme of the seventh Presidents' Conference held January 22-23 by the New Brunswick Association of Registered Nurses. Twenty-one presidents and vice-presidents representing the 11 chapters in the province attended the sessions, held at NBARN headquarters.

Purposes of the conference were two-fold: to assist present and future chapter presidents in carrying out their responsibilities of office; and to provide an opportunity for chapter leaders to meet and discuss common problems and experiences.

The program covered several areas of chapter programming, including chapter bylaws, executive committees, standing committees, program and finance committees. Problem-solving situations, a skit, and group discussion were among the methods of presentation.

Other items discussed were: NBARN Act and By-Laws, job responsibilities of provincial office staff, the new Public Service Labour Relations Act, the 14th Quadrennial Congress of the International Council of Nurses and the 1970 General Meeting of the Canadian Nurses' Association, to be held in Fredericton.

PEI Nurses Granted Salary Increases

Charlottetown, PEI. —Prince Edward Island nurses working in hospitals financed by Hospital Insurance have been granted a salary increase raising their basic salary from $326 to $396 per month. The increase was effective January 1, 1969.

The increase falls short of the original demands of the nurses: a 10 percent increase retroactive to January 1, 1968, and a further 15 percent increase effective January 1, 1969. This would have brought the basic salary to $424 per month. The nurses had been threatening mass resignations previous to the settlement.

Under the new terms, nurses would reach a maximum salary of $458 in four years, or in four increments. In the past there had been five increments.

Nurses working for provincial government hospitals and agencies are expecting a similar increase, possibly retaining the five increments. Their increase will be effective April 1, 1969.

The basic salary for nursing assistants has been increased to $250 with five increments to a maximum of $357 per month.

Community College in Ontario To Start Nursing Program

Toronto. —In September 1969, Humber College of Applied Arts and

Technology will become the first community college in the province to add a two-year diploma nursing course to its curriculum.

The program, developed by Humber College and St. Joseph's Hospital School of Nursing, will be similar to the program presently being carried out at St. Joseph's.

Students who enroll in the College program will use the clinical facilities at St. Joseph's Hospital and Etobicoke General Hospital, when the latter is completed. Annual tuition fees will be $185 plus the cost of books, uniforms, and laboratory fees. Students will have six weeks vacation annually.

In an interview with *The Canadian Nurse,* Albert Wedgery, president of the Registered Nurses' Association of Ontario, commented favorably on Humber College's plans.

"This announcement is an encouraging sign of changing attitudes about the kind of preparation that nurses need to function properly in today's complex society," Mr. Wedgery said. "With other Canadian provinces having moved, or about to move, their diploma programs in nursing into the stream of general education, this new opportunity at Humber College anticipates a similar, but gradual, development in Ontario. Perhaps the most enlightening aspect of this proposed program," he continued "is the fact that a hospital school of nursing, with a long and notable history, has decided to merge into an educational system that provides a broader professional base for nursing practice."

Collective Bargaining Workshops Held Across Manitoba

Ottawa.—A series of special educational workshops on collective bargaining is being held across Manitoba, sponsored by the employment relations committee of the Manitoba Association of Registered Nurses. The series runs February 17 to March 13.

Conducting the workshops is Glenna Rowsell, consultant in social and economic welfare for the Canadian Nurses' Association, assisted by MARN staff and members of the employment relations committee.

Two workshops are being held in Winnipeg, the others in Swan River, Dauphin, Flin Flon, Morden, Russell, and Brandon. Aim of these workshops is to interpret to MARN members: clarification of collective bargaining; the function of a professional association in collective bargaining; the responsibility of individual members; and the effects of working under a collective agreement.

New Brunswick Nurses To Be Granted Collective Bargaining Rights

Fredericton.—Some 3,600 New Brunswick nurses were among 30,000 public service employees recently granted full collective bargaining rights in the Public Service Labour Relations Act, passed December 4, 1968 by the New Brunswick Legislature. Prior to this, only 20 percent of the public service employees had collective bargaining rights. Nurses were among those excluded.

The new Act, which comes into effect on a date fixed by proclamation, forbids employees to picket, parade, or demonstrate, and forbids the employer to replace striking employees. When negotiation fails, the employees have the choice of arbitration or strike action with provision for continuation of essential services if strike action is chosen.

Under the Act, employees are divided into four categories. The majority of nurses are included under the category of

TO PLAN FOR A LIFETIME



Marriage is a responsibility that often requires both spiritual and medical assistance from professional people. In many instances a nurse may be called upon for medical counsel for the newly married young woman, mother, or a mature woman.

"To Plan For A Lifetime, Plan With Your Doctor" is a pamphlet that was written to assist in preparing a woman for patient-physician discussion of family planning methods. The booklet stresses the importance to the individual of selecting the method that most suits her religious, medical, and psychological needs.

Nurses are invited to use the coupon below to order copies for use as an aid in counselling. They will be supplied by Mead Johnson Laboratories, a division of Mead Johnson Canada Ltd., as a free service.

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hospital board employees. A small number of nurses are in another category that includes civil servants. The government Treasury Board has been designated as the employer for these groups for purposes of the Act.

The Act authorized the establishment of a Public Service Labour Relations Board, to be an independent body responsible for supervision of the interests of employees and employers, and safeguarding the interests of the public. A Public Service Arbitration Tribunal, consisting of a chairman and representatives from labor and management, will also be established.

The Act specifies that the collective bargaining will begin with a 45-day negotiation period. If no agreement is reached, a conciliation officer must file a report within 14 days. At the same time the employer submits to the Public Service Labour Relations Board a list of individual employees and work categories required to maintain essential services; the union may contest these designations, but the final decision rests with the Labour Relations Board.

After the conciliation officer's report, 15 days are allowed for the establishment of a conciliation board; this board is given 30 days to make its report. At this time either party may request that the Public Service Labour Relations Board declare a deadlock. After the chairman is satisfied that a deadlock exists, he has three days to declare it and to see if the parties will submit their disagreements to arbitration. If they agree to arbitration, both groups must submit statements on the points of disagreement to the arbitration tribunal within 14 days. Work continues during this period. If both parties do not agree to arbitration, the employees' bargaining unit may hold a strike vote.

The New Brunswick Association of Registered Nurses called the Act "fair and reasonable." The Association is prepared to apply for certification as a bargaining agent as soon as possible under the new Act.

Workshops On Test Construction To Be Held in London

London, Ont.—Vivian Wood, assistant professor of nursing at the University of Western Ontario, will conduct a workshop on test construction at the University May 5-7.

The workshop will concentrate on a discussion of measurement, exploration of examination blueprint models, and essay and objective examinations. Participants will be developing skills in writing essay questions, developing blueprints for examinations, preparing model essay answers, and marking essay answers. Skills in item-writing and item-analysis will also be discussed, and the final assessment of students will be explored by examining the various models in grading.

Cost of the course is $75, plus $7 per night for accommodation. The course is limited to 30 people.

1969 Fee$ Are Due

Ottawa. – Nurses in four provinces will pay more for membership in their provincial associations in 1969, according to Ernest Van Raalte, general manager of the Canadian Nurses' Association.

Nurses' fees, however, are,on the average, lower than fees for other professional or union groups, Mr. Van Raalte added. "For example, union dues for postal workers are a minimum of $5 a month – or $60 a year (the local unit can set a higher rate if it wishes). This is considerably higher than the association fee for nurses, which includes other benefits, such as membership fees in the national and international nursing associations and costs of the provincial bulletins and the national nursing magazine," he said.

Mr. Van Raalte said that association fees for social workers are higher than those of nurses; they range from a low of $45 in one province to $65 in another. The yearly association fee for doctors in the Canadian Medical Association is $300.

Association fees for nurses registered to practice (renewals) in the 10 provincial associations are:

	1968	*1969*
Alberta	$30	$35
British Columbia	$37	$37
Manitoba	$35	$35
New Brunswick	$30	$30
Newfoundland	$27	$35
Nova Scotia	$25	$25
Ontario*	$35	$35
P.E.I.	$25	$30
Quebec	$25	$25
Saskatchewan	$27	$40

*Ontario nurses also pay $5 to the College for registration fees.

Nurses' Associations Granted Salaries That Exceed Those Set By OHSC

Toronto. —Through arbitration procedures, two groups of Ontario nurses have been awarded salaries that exceed those established by the Ontario Hospital Services Commission.

The Nurses' Association, Metropolitan General Hospital in Windsor, has been awarded a starting salary of $480 for general staff nurses, with a maximum of $585 to be achieved by 5 annual increments of $21. Salaries for all other levels included in the contract are also above the OHSC stipulated figures. The Commission's declared policy for nurses' salaries for 1969 is based on a starting salary of $470 for a staff nurse, with a maximum salary of $570, achieved by 5 annual increments of $20 per month.

The Nurses' Association, St. Joseph's Hospital, Peterborough, received starting salaries of $475.

In the Metropolitan contract, provision is made for 3 weeks vacation after 1 year, 4 weeks after 5 years, and 5 weeks after 25 years. Teachers are to receive 4 weeks after 1 year, and 5 weeks after 25 years. One important provision in the contract was for a continuing "Professional Committee," made up of representatives of the Nurses' Association and the hospital. Under benefit plans, the hospital pays 100 percent for single coverage and 66-2/3 percent for family coverage.

According to Isabel LeBourdais, public relations officer, Registered Nurses' Association of Ontario, "It is significant that, except for nurses at Riverview Hospital, Windsor, it is only the arbitration procedure that achieves a breakthrough from pre-determined standards set by a third party [OHSC]that is not present at negotiations."

The Nurses' Association, Riverview Hospital, achieved the first collective bargaining contract in a hospital in Ontario. Under the present contract their starting salary moves to $500 per month, June 1, 1969.

ANA Supports AMA's Move Against Discrimination

New York. – The American Nurses' Association has congratulated the American Medical Association on its move to eliminate discrimination on the basis of color, creed, race, religion, or ethnic origin. A meeting of the AMA in Miami in December amended the bylaws of the Association to discourage and eliminate discrimination in membership.

Dorothy A. Cornelius, president of ANA, had sent a message to AMA president Dwight L. Wilbur before the meeting, expressing an interest in the proposed changes, and citing the ANA's experience in integration.

ANA began its fight to eliminate discrimination in membership in 1946 by establishing a category of individual membership, allowing Negro nurses in states where the nurses' associations practiced discrimination, to join ANA directly. Discrimination in state and local districts disappeared by 1964. □

names



Loral Graham, who joined the staff of THE CANADIAN NURSE as editorial assistant in September 1967, and later was promoted to assistant editor, resigned last month. Mrs. Graham and her husband, who is employed by the federal government's Department of External Affairs, expect to leave Canada shortly for a posting abroad. Accompanying them will be a new member of their family.

Mrs. Graham was graduated from Carleton University with an honors degree in English in 1966. She was employed by the National Research Council as an information services officer before joining the editorial staff of THE CANADIAN NURSE.

During her one and one-half years with the journal, Mrs. Graham was responsible for all of the magazine's departments with the exception of the "News" section. She wrote several lively articles, one of which ("Defend Yourself, August 1968) received nation-wide publicity. This same article had the distinction of being the first article from THE CANADIAN NURSE to appear, in condensed form, in the *New York Times.*



Carol Kotlarsky became editorial assistant for THE CANADIAN NURSE in February 1969. A 1967 journalism graduate from Carleton University, Ottawa, Miss Kotlarsky comes to Ottawa from Quebec City where she was employed as an editor by the federal Department of Forestry and Rural Development.

While a student at Carleton University, Miss Kotlarsky published articles in *School Progress,* did contract writing for the Canadian Government Travel Bureau, and worked part-time for the *Financial Times of Canada.*

University of Toronto has granted the degree of Doctor of Philosophy to **Josephine Flaherty** (B.Sc.N., B.A., M.A., U. Toronto). Dr. Flaherty earned the degree through the Ontario Institute for Studies in Education and is the first graduate of the University of Toronto School of Nursing to obtain a doctorate.

After graduating from the school of nursing, University of Toronto, in 1956, Dr. Flaherty was charge nurse at the Red Cross Outpost Hospital, Matachewan, Ontario. From 1960 to 1962 she taught at Nightingale School of Nursing, Toronto, while working for her B.A. in history. After lecturing at the University of Toronto School of Nursing for two years, Dr. Flaherty took the M.A. degree in the University's School of Graduate Studies, at the same time acting as part-time research assistant.

At the Ontario Institute for Studies in Education, Dr. Flaherty is an assistant professor in the Department of Adult Education, where she teaches courses in psychology and adulthood, and in research and statistics. She is involved in research in adult education and in education for nursing and the professions. In addition, Dr. Flaherty serves as a consultant in nursing in the field of evaluation and program planning.



Marie Therese Sabourin (R.N., St. Paul's H., Vancouver; B.Sc.N., Seattle U., Wash.; M.N., U. Washington) is the new director of nursing service for the Registered Nurses' Association of British Columbia. She was formerly director of nursing service at St. Paul's Hospital, Vancouver.

Miss Sabourin was born in Ottawa and received her early education and teacher's training there. After receiving her teaching certificate in 1945, she taught in Ottawa elementary schools for five years.

She has served on the nursing staff at hospitals in Saskatchewan, Alberta, and British Columbia and has been as active member of professional nursing association activities. □

Nursing Sister Receives OBE



Ottawa.—Governor General Roland Michener is seen presenting the Order of the British Empire (military division) for gallantry to Captain (N/S) Joan Cashin, 27, a flight nurse with the Royal Canadian Army Medical Corps. The investiture took place in a ceremony January 4 at Government House. Nursing Sister Cashin received the OBE for her bravery in giving medical assistance at the crash scene of a Czechoslovakian aircraft near Gander International Airport September 5, 1967. Now stationed at Canadian Forces Base Trenton, Nursing Sister Cashin is credited with saving many lives.

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dates

March - May, 1969
Continuing education courses for nurses, The University of British Columbia. March 20-21: The maternity cycle viewed as a developmental crisis. May 1-2: Preoperative nursing care. May 8-9: Nursing assessment. May 15-16: Nursing the adult with long-term illness — sociological aspects. For information write to: Continuing Education in the Health Sciences, Task Force Building, The University of British Columbia, Vancouver 8, British Columbia.

March 20-21, 1969
Workshop on hearing, measurement, and conservation, University of Toronto. Intensive training for occupational health nurses, industrial audiometric technicians, and safety supervisors. Apply to: Special Programmes, Division of Extension, University of Toronto, 84 Queen's Park, Toronto 5.

March 20-23, 1969
April 14-17, 1969
Regional conferences on the use of audiovisual aids in nursing, sponsored by the Registered Nurses' Association of Ontario. To be held in Ottawa in March, and Fort William in April. Fee: RNAO members, $25; non-members, $35. Write to RNAO, 33 Price St., Toronto 5.

March 24-29, 1969
Symposium on recovery room and intensive care nursing, Grace General Hospital, Winnipeg. Registration: $20. For further details: Miss J.W. Robertson, Director - Inservice Education, Grace General Hospital, 300 Booth Dr., Winnipeg 12.

April 7, 1969
World Health Day
Theme: Health, Labor, and Productivity.

April 13-17, 1969
American Association of Neurosurgical Nurses Meeting, Cleveland, Ohio. Information may be obtained from: Miss S.M. Sawchyn, 99 Fidler Ave., St. James 12, Manitoba.

April 14 - May 9, 1969
May 12 - June 6, 1969
Rehabilitation Nursing Workshops, University of Toronto. Four-week course for R.N.s employed in acute general and chronic illness hospitals, nursing homes, public health agencies, and schools of nursing. Tuition fee: $150. Apply to: Division of University Extension, Business and Professional Courses, 84 Queen's Park, Toronto 5.

April 20, 1969
Second Annual Dialysis Symposium for Nurses, held in conjunction with annual meeting of American Society for Artificial Internal Organs, at Chalfonte-Haddon Hall, Atlantic City, New Jersey. Organized by the US Public Health Service's Kidney Disease Control Program. For further information write: Michael A. Byrnes, Information Services Section, Dept. of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, 4040 North Fairfax Dr., Arlington, Virginia 22203.

April 28 - May 2, 1969
Final workshop of the Extension Course in Nursing Unit Administration, Regina, offered in English and French to registered nurses in administrative positions who are unable to attend university. Sponsored by the Canadian Nurses' Association and the Canadian Hospital Association. For further details and application forms for the 1969-70 class, write to: Director, Extension Course in Nursing Unit Administration, 25 Imperial Street, Toronto 7.

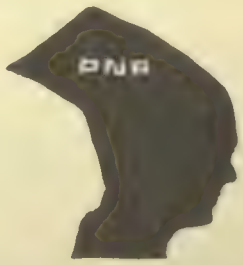
May 5-7, 1969
Workshop for teachers on test construction, conducted by Professor V. Wood, School of Nursing, The University of Western Ontario. Theme: Task-oriented work sessions on essay questions, models for marking essay questions; objective examinations and item-writing practice sessions; and final assessment of student nurses. Send applications to: Miss Angela Armitt, Summer School and Extension Department, The University of Western Ontario, London, Ont.

May 12, 1969
Alumnae Association of the Toronto General Hospital School of Nursing, 75th anniversary. Events for the week of May 12 include tours of the new school and residence, graduation exercises, and dinner at the Royal York Hotel. For dinner tickets ($8.50) and further information write: Mrs. Grieg Brown, 27 Thorncliffe Park Drive, Apt. 301, Toronto 17.

May 13-16, 1969
Alberta Association of Registered Nurses, annual convention, Macdonald Hotel, Edmonton, Alberta.

June 16-18, 1969
Conference on nursing education for visitors to the International Council of Nurses Quadrennial Congress. Sponsored by the school of nursing and alumni association, University of Toronto. June 19-20: tours in Toronto and environs to be arranged at request of persons attending conference. Apply to the Secretary of the School, University of Toronto School of Nursing, 50 St. George St., Toronto 5.

June 22-28, 1969
International Council of Nurses' Quadrennial Congress, Montreal. Fee: before Mar. 31, $40; after Mar. 31, $60. Write to: ICN Congress Registration, 50 The Driveway, Ottawa 4, Ont. □



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By **Audrey Latshaw Sutton,** R.N., formerly Director of Nursing Service, Edgewood Hospital, Berlin, N.J. and Instructor, Wilmington (Del.) General Hospital

Used by more than 80,000 nurses, this source book of advanced clinical nursing techniques has now been made even more valuable in the new Second Edition. In clear, precise language supplemented by more than 750 explicit drawings, Mrs. Sutton tells precisely how to perform hundreds of nursing functions, from intramuscular injection to caring for the patient in hyperbaric oxygen therapy. In the first part of the book she describes the basic techniques that are common to all areas of clinical nursing; then she takes up specialized techniques used in disorders of each of the body systems. Nurses by the tens of thousands have found this book unparalleled as an advanced text, as a "refresher," and as a reference at the nursing station. It is even more valuable in the new Second Edition.

About 460 pages, with over 750 illustrations. About $9.20. Ready March.

NURSING OF CHILDREN: A Guide for Study

By **Debra Hymovich,** R.N., B.S., M.A., University of Florida

This new study guide and workbook in pediatric nursing does more than just present facts and techniques. It uses a realistic case study approach that calls for the creative integration of knowledge — just as actual nursing practice does. In this book you read about a case as you would encounter it on the pediatric service. You are asked to answer questions that review your knowledge of anatomy, physiology, and pharmacology. You are asked to make plans for nursing care and to interpret the results of tests, and you plan the instructions and explanations and would give the patient's family. Nineteen specific conditions are discussed; among them they encompass almost the entire range of pediatric nursing.

About 250 pages, illustrated. About $4.90. Ready March.

FUNDAMENTAL SKILLS IN THE NURSE-PATIENT RELATIONSHIP

By **Lianne S. Mercer,** R.N., B.S.N., M.S., formerly of the University of Michigan, and **Patricia O'Connor,** Ph.D., University of Michigan.

A nurse educator and a psychologist have jointly developed a teaching program for the vitally important but often neglected skills of interpersonal relations. This seven-hour instructional unit thoroughly covers such topics as "Utilizing Resources in Patient Care," "Structuring the Professional Relationship," and "Communication Skills." It answers such questions as: What should you say if a patient refuses a treatment? How should you respond when a patient asks about his diagnosis or prognosis? How can you get more information from written records and from the patient himself when you need it? The principles upon which effective nurse-patient relationships are based become clear as you proceed through the program.

About 150 pages. About $3.80. Ready March.

GROWTH AND DEVELOPMENT OF THE YOUNG CHILD 8th Ed.

By the late **Marion Breckenridge,** M.S., formerly of the Merrill-Palmer Institute, and **Margaret Nesbitt Murphy,** Ph.D., Purdue University.

Now in a new Eighth Edition, this text unfolds the physical, mental, emotional, and spiritual development of the preschool child. It explains current concepts of growth, development, and maturation and traces the interactions between them. This book will enrich the understanding of anyone who works with children.

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in a capsule

Don't call me: I'll call you

A doctor in Manitoba tells this amusing anecdote:

"Following a cerebrovascular accident, I spent several months in the rehabilitation ward of a large hospital. I then was discharged to complete the adjustment in my home. Arrangements were made for the rehabilitation department to loan me an ordinary metal urinal, familiarly known as the 'bottle.'

"Following delivery of the 'bottle,' I received a surprising letter. It stated:

> You are responsible for maintaining the loaned equipment in good condition. Our technician will call at your home in the near future to show you how to use it.

"Although the letter came some time ago, the technician has not yet called. I have just had to make use of the equipment as best I could without the benefit of his specialized knowledge."

Nursing can turn you on

Soul music and space suits are not generally used to attract young people into nursing. But a high school in Rochester, New York, was the scene, and the American Nurses' Association, in league with Ex-Lax Inc., was the sponsor of just such a happening.

The happening was called a "Soul Seminar" and was aimed at underprivileged junior high school students. Fifteen hundred students, mainly Negroes, attended.

"The Fantastic Entertainers," a Rochester musical group, provided a "soul" background, while the nurse of 2001 – a moon-nurse – modeled her uniform, complete with space boots and moonbeam. A copy of a new pamphlet, "Nursing Can Turn You On" was given to every student, and a Rochester nurse narrated an original slide and "live" presentation of "Nursing – Past, Present, and Future," which emphasized the history and contributions of black women to nursing. A Negro nurse educator gave a first-person account of "Why I Became a Nurse," and the students joined in a question and answer period.

The ANA is deeply involved in matters of human rights and has taken a public stand on civil rights. The Association is concerned about the low percentage of Negro students entering nursing: although 11 percent of the U.S. population is black, only 3 percent of nursing students are Negro. The Rochester soul seminar was only the beginning of an accelerated drive by the ANA to make American nurses more truly representative of all Americans.



Want International friends?
You're sure to find them at the ICN Congress in Montreal this June.

A bacchanalian tale

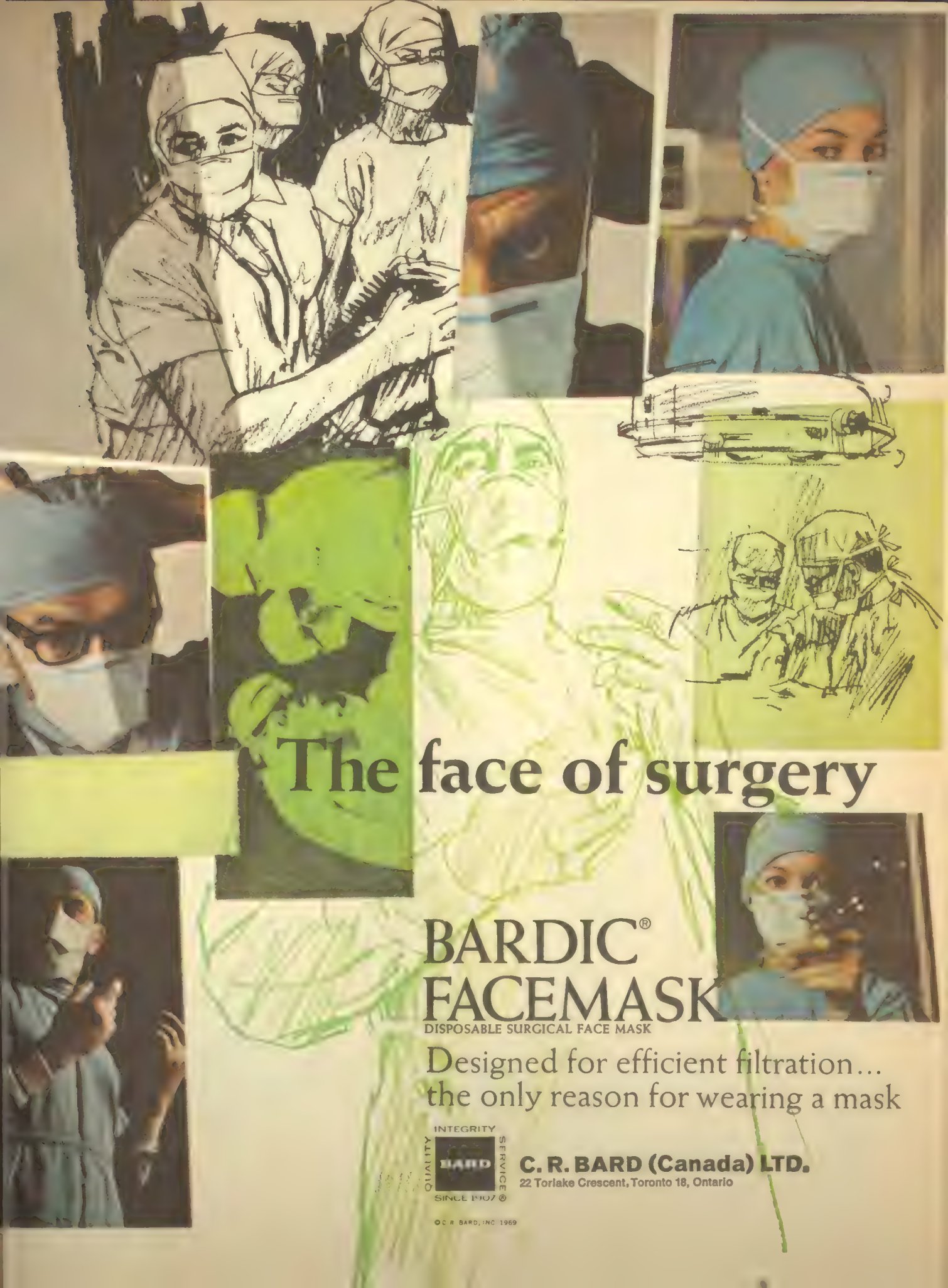
Throughout history, wine has been used as a tranquilizer. Modern doctors have added to the therapeutic uses of wine. They have prescribed wine for anemic patients, since wine is rich in iron; for diabetics, since dry wine is a no-sugar energy source that requires no insulin; for cardiovascular diseases, since it lowers blood cholesterol and is relaxing; for infectious diseases, since wine pigments have antibacterial action; and for kidney diseases, as wine is an effective diuretic.

In the January-February issue of *Modern Nursing Home,* two Chicago doctors strongly recommend that wine be served in hospitals along with the evening meal. Dr. Vincent Sarley, medical director of Wrightwood Extended Care Facility, and Dr. Robert C. Stepto of the College of Medicine, University of Illinois, have closely compared the attitudes of patients who drank wine with dinner with those of patients on a "dry" diet. It appears that wine-imbibing patients not only sleep better than their teetotalling fellows, but they also become supremely satisfied with life in a hospital bed.

- 90 percent of wine-consuming patients were happy with visiting hours and regulations, whereas only 43 percent of non-wine patients were.
- 100 percent of wine-drinking patients found their beds comfortable, compared with only 57 percent of non-wine patients.
- 85 percent of wine-drinking patients were happy with their food, whereas only 43 percent of non-wine patients were.
- 43 percent of wine-drinking patients liked their doctors, compared with only 18 percent of non-wine patients.
- 83 percent of non-wine patients complained of being awakened too early in the mornings, although only 40 percent of the wine-drinkers did.
- 78 percent of wine-drinking patients found their rooms quiet enough, in comparison with only 57 percent of non-wine patients.

Lest you have visions of beaming "wine patients" cheerily gobbling their food between healthy swills from a large green bottle and giving their nurse an affable pinch and their doctor a rosy-nosed smile before passing out for the night with a final hiccup, Drs. Sarley and Stepto report that the patients under study were served only *two ounces* of wine with dinner.

Now that's what we call the power of suggestion! □


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So if you're looking for a pair of Oxfords that will stand up for you, buy White Uniform by Savage.



Remember the Foot Health Seminar – Hospital for Sick Children, Monday, June 2nd.

Thought and action

This biennium, nurses must make a serious decision about the future role of their national association. Nurses have directed the Canadian Nurses' Association to enlarge its services — but at the same time they have decided to hold the line on the budget. Some of the implications of this paradox are examined in this article.

Ernest Van Raalte

The financial status of the Canadian Nurses' Association has become so tight that even the cost of stamps threatens to put the Association into the red.

Unfortunately, the cost of stamps is not, for the CNA, a minor matter. In fact, the postal rate increases that go into effect April 1 will cause something of a financial crisis.

At the next general meeting of the CNA, nurses must make some serious financial decisions. These need to be considered carefully, because they will influence the future of nursing in Canada for some time to come.

At the last general meeting, the decision on finances was – for all practical purposes – postponed. A special ad hoc committee was appointed to investigate all implications and alternatives of national and provincial responsibilities, including fees. It will report back to the general meeting in Fredericton in June 1970.

In the meantime, the CNA was asked to tighten its belt, and to manage the estimated 13 percent increases in costs on the same budget as for the 1966–68 biennium. This, the CNA might have been able to do, if it had not been faced with the postal increases.

Postal rates are up. The cost to the CNA for mailing journals will be about 15 times as much as it was before. These costs will not wait until the next biennium. They start next month. The increased postal rates passed by the House of Commons excluded THE CANADIAN NURSE and *L'infirmière canadienne* from the privileged postal rates they have enjoyed in the past. The journal mailing costs will rise by about 15 cents per copy or $1.80 a year per member. This is effective April 1, 1969.

As well, the CNA has had to go forward with programs already committed, such as the National Testing Service and the International Council of Nurses' meeting.

The special ad hoc committee and the Board of Directors will debate wisely and report fully. The decision, however, rests, as it always does, with you – the individual nurse.

1966-68 — Years of Expansion

At the 33rd General Meeting of the Association in Montreal in July, 1966, the members endorsed a program of increased activities for the national association. They approved an increase in membership fees from $6 to $10 to meet these activities. This meant many changes and an expanded role for CNA.

For the first time, the Association was able to hold meetings of provincial permanent staff in counterpart groups. The 10 provincial members on social and economic welfare, public relations, nursing service, and nursing education were able to come together to identify common problems and work together toward their solution.

An advisory service to provincial associations was begun. CNA consultants went from coast to coast to conduct collective bargaining workshops and conferences (19 in that biennium), nursing service workshops (9), library workshops (3), and a workshop for nursing faculty (1). All provincial associations used the services of CNA consultants in these areas and as well turned to CNA for help in research and statistics and in organization and management.

The important work of communicating information about nursing and its beliefs was expanded. Improvements in THE CANADIAN NURSE and *L'infirmière canadienne* were effected, and eight new books and pamphlets were produced. These included *The Leaf and the Lamp* – a history of CNA; *Countdown 1967* – the first book on Canadian nursing statistics; *PR Pointers* – a practical guideline for communications between nursing and other groups; and *CNA: What It Is, What It Does* – a pamphlet addressed to senior government officials, allied organizations, the press, and others in positions of influence.

CNA also increased its participation in the work of other organizations, for this gave it the long-desired opportunity to interpret beliefs and policies about nursing to other agencies. Relationships were extended with groups such as the Canadian Medical Association, the Canadian Hospital Association, the Canadian Public Health Association, the Canadian Council on Hospital Accreditation, and the Department of National Health and Welfare. A clearer understanding of nursing's goals and policies was achieved through the active participation of CNA representatives at the many conferences and committee meetings with these agencies.

All these expanded activities were designed to improve the status and condition of Canadian nursing and to

Mr. Van Raalte is General Manager of the Canadian Nurses' Association, Ottawa.

strengthen the position of the profession. The results obtained since this program went into effect in 1966 are remarkable.

1968-70 — Hold the Line

At the general meeting in Saskatoon in July 1968, the Board of Directors reported proudly on the activities of the 1966–68 biennium. They advised that the $10 fee per member would accommodate rising costs and that the Association's activities could be maintained at the same effective level.

However, a motion was passed "that for the 1968–70 biennium only, in member (provincial) associations whose membership exceeds 20,000, the full annual fee per member be $6.00 and in member associations whose membership is 20,000 or less the full annual fee per member be $10.00 and that the Board of Directors be empowered to adjust the budget accordingly."

This had the effect of reducing the income-per-member from $10.00 to $8.67. The Board of Directors faced a dilemma: to reduce expenditures by over 13 percent while costs were increasing in similar proportion, and to do so without damaging the effectiveness of the programs.

On another motion from the general meeting, the Board of Directors appointed a committee to study the question of membership and fee structure and make recommendations to the provincial associations six months prior to the 1970 general meeting. This committee will examine, too, the national and provincial associations' functions and relationships and the incorporation documents and bylaws of CNA.

At present, all members of provincial associations are members of the Canadian Nurses' Association and the International Council of Nurses. The fee for membership in both these organizations is a part of the annual fee that the provincial association pays to CNA on behalf of the member.

Prior to the Motion reducing the annual fee for members in provincial associations with over 20,000 members to $6.00 for this biennium, all individuals contributed equally to the financing of CNA and ICN.

Balancing the budget

Based on a $10 per individual nurse fee, the proposed 1968–70 budget looked something like this:

ICN Individual member fee	.40
Net cost of journals	$ 3.00
Board and committee meetings	$ 1.94
Research and advisory services	$ 1.72
Sponsorship	$ 1.41
Library and archives	.92
Public Relations	.61
	$10.00

With less money coming in, the Board of Directors has to consider which of these services can be cut. Certain of the costs – such as the ICN fee, costs of holding statutory meetings, and building costs – are fixed.

Even before the Board's first major meeting of this biennium, the task was further complicated by the increase in postal costs.

The Board of Directors and the Ad Hoc Committee on Functions, Relationships, and Fee Structure will look at each area and propose how the Association will meet its obligations during the next year. They will closely examine the following areas:

ICN individual fee

The ICN is a federation of 63 national nursing associations. Your membership fee and similar fees from the individual members of all the member national associations around the world finance the ICN. Canadian nurses, as hosts of the ICN Congress in Montreal this summer, can hardly withdraw membership at this time.

Net costs of journals

Each member of the CNA receives monthly issues of the journal in the language of her choice. The $3.00 budget allocation represents the net cost per member after advertising revenue. It covers the salary and travel expenses of the editorial staffs, and the costs of postage, printing, translation, design, art, photography, and all other costs connected with journal publication and circulation. The new postal rates will raise costs by $1.80. Changes in quality, size, or frequency of publication could considerably reduce advertising revenue.

Board and committee meetings

This covers the travel costs and all other expenses connected with convening meetings of the Board of Directors, the Executive Committee, the standing committees, and general meetings that are mandatory by statute. It also covers the cost of ad hoc committee meetings and other non-statutory meetings convened for special purposes.

Research and Advisory services

The research and advisory staff plan and conduct all workshops and provide the advisory services to provincial associations mentioned earlier. In addition, they compile and publish statistical data, write and publish technical papers, participate on inter-agency committees, prepare briefs to government commissions, plan and conduct provincial counterpart conferences, and act as secretaries and resource people to the various standing committees. This portion of the fee covers the salary and travel expenses of the Research and Advisory staff, and the cost of counterpart meetings, collecting and processing statistical data, and the printing of technical publications.

Sponsorship

This is the amount set aside to contribute to and administer such activities as the Canadian Nurses' Foundation, and CNA Student Loans and to subsidize special nursing events, such as the ICN Congress.

Library and Archives

This covers the costs of preparing bibliographies and providing library research services for all CNA studies and programs. As well, book loans are made to individual members across Canada, and to nursing students and others interested in nursing. The CNA Library is the only comprehensive collection of nursing literature in the nation. Its repository collection of nursing studies is a major resource for research in nursing in Canada, and the periodical collection of some 300 titles is probably one of the best in the world. The cost of all acquisitions, subscriptions, binding and supplies, as well as the salaries and travel expenses of library staff, is covered by this portion of the fee.

Public Relations

The public relations officer gathers, prepares, and distributes information about nurses and nursing activities to the public through press, television, and other media; to the provincial associations through constant communication with provincial counterparts; and to the members through the news columns of the journals. She also plans and conducts provincial public relations counterpart meetings. This portion of the fee covers the salary and travel expense of the PRO, consultant fees, the cost of counterpart meetings, promotional publications, and special public relations events.

The portions of fee allocated above for the various activities cover all CNA costs, including the cost of owning, operating, and maintaining the national headquarters building and the salaries and expenses of administrative and general office personnel.

Think — because you must act

The problem is immediate, and it places a serious responsibility on each member of the Association. The Board of Directors and the Ad Hoc Committee will deliberate these problems on your behalf and be prepared to make recommendations at the next general meeting.

But it is up to each individual nurse to consider the alternatives objectively. You must give direction to your voting delegates so that the right decisions are made.

The future of nursing is in the hands of the nurses. The time has come for action. Action without thought or thought without action can be equally disastrous. □

Infections in the hospital

Modern hospitals may be as up-to-date as tomorrow, but they have not solved yesterday's problem — infection. Antibiotics alone cannot control infections; the first line of defense rests with diligent staff members, aided by an active infection control committee.

Dorothy Pequegnat



What do you mean I look a cyte? I am a 'te!"

Over 100 years ago, Joseph Lister published his first notes on wounds and abscesses and stressed the antiseptic treatment of wounds. His liberal use of phenol led to a decrease in the number of infections, and so began the era of antiseptics. This was replaced by the aseptic era, based largely on the teaching of Florence Nightingale.

In 1929, Sir Alexander Fleming changed the whole outlook on microbial disease with the discovery of penicillin and thus began the antibiotic era. Antibiotics would put an end to infections, it was thought, but as everyone must now recognize, this hope has not been fulfilled.

A noticeable decrease in infections in hospital did follow the initiation of antibiotics, and the hospital and medical staff became less concerned about the dread "spiked temperature" and the "jaws of death" on the temperature-pulse-respiration charts. Then, about 12 years ago, some bacteria, especially some strains of *Staphylococcus aureus,* became resistant to the antimicrobial drugs, causing gross infection and sometimes mortality.

Early in 1958, the first of five yearly meetings was held at the National Research Council in Ottawa. The objective of these meetings was to provide a focal point for the submission of proposals regarding the control of Staphylococcal infections in hospitals. In that same year, a national conference on "Hospital Acquired Staphylococcal Disease" was sponsored by the United States Public Health Service and the National Academy of Sciences, and in England lectures were started at the Royal College of Surgeons on "Spread of Infections."

This world-wide concern over cross infections in hospitals has led to today's hospital infection control committees and to considerable knowledge about hospital infections. The organism that caused this concern about cross infection in the 1950's – a particularly virulent and antibiotic-resistant strain of *Staphylococcus* aureus – had developed, and was flourishing in patients whose normal flora had been destroyed by antibiotics. Antibiotics, in this instance, were not useful as treatment. However, this virulent strain has now more or less died out.

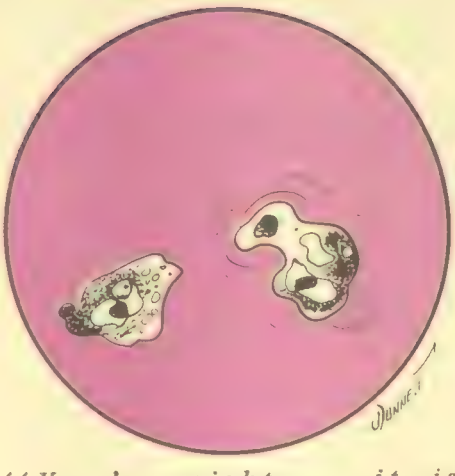
Today, most hospitals now do routine antibiotic sensitivity testing on all cultures to help identify any infection with antibiotic-resistant bacteria.

For many years it was believed that bacteria reproduced by simple binary fission and that resistance to antibiotics arose as a result of mutation. Recently it has been found that bacteria may reproduce by sexual conjugation and that, by means of a so-called resistance transfer factor, or R factor, resistance to one or more antibiotics may be transferred from

Mrs. Pequegnat has been the Infection Control Officer at the Ottawa Civic Hospital since the beginning of the present program in July 1967. In 1966 she participated in a preliminary research project, which led to the start of the present program. She is a graduate of the Ottawa Civic Hospital and has a certificate in public health and a diploma in microbiology (infection control) from the University of Ottawa, Canada.



"... and stop referring to me as 'that foreign body.'"



"You're right . . . it is pepp..p..p..a..a..a..a...a...CHOO!"



one strain or species of bacteria to another. Because of this, a relatively harmless organism can pick up the R factor causing infection or transfer its R factor to a more virulent organism which could cause gross infection.

Many new antibiotics are being produced for use in hospitals today, but it is important that antibiotics be recognized as a second line of defense and that hospital staff understand and strive to block the many other channels where infection can spread.

Endogenous or hospital spread?

Almost half the infections seen in hospital are in patients admitted with their infection. Those noted after the patient has been admitted are called "hospital acquired" infections. Infections may also occur after the patient goes home; these the hospital may never hear about.

Many so-called "hospital-acquired" infections really occur by endogenous spread or are affected by one of many variables; it can be difficult to say just which are caused by cross infection. It is important not to divorce the infection from the circumstances surrounding it, just as it is important that the hospital examine procedures to prevent cross contamination and cross infection.

Nurses and other personnel sometimes fear infection; this can cause danger to the patient both mentally and physically, if it leads to an ostrich attitude and neglect in nursing care. Much of this fear is founded on inadequate understanding of how infections are transmitted and on a failure to realize the safeguards offered by good technique.

For example, gas gangrene is a very serious condition for the patient and one we hope never to see. However, incidence of cross infection between patient and ward personnel is almost unknown. The organism *Clostridium perfrigens,* which causes gas gangrene, is around us most of the time, and some 20 to 30 percent of the population are carriers, but the organism needs special conditions to produce toxins. General cleanliness and the use of steam sterilization rather than boiling or cold sterilization lessen the chance of the spore getting into deep tissue, as it once did.

Even those hospitals with good infection control programs will always have problems with infections – especially those admitted from the community. Also, because of the use of immunosuppressive drugs, steroid therapy, long surgical procedures, and increasing numbers of patients with traumatic injuries and terminal disease, hospitals are dealing with many more high risk patients who are susceptible to infection. Hospitals therefore must consider even more precautions.

In general, a large inoculum or gross contamination will lead to cross infection. Each department must carefully examine its own area and set up rigid standards for cleanliness, whether for the incubator in the nursery, the whirlpool bath in physiotherapy, the dialysis machine in urology, the ECG equipment in the intensive care unit, or the general housekeeping all through the hospital.

Personnel must also realize that to give good nursing care it means coming in close contact with patients. Good nursing techniques help prevent cross infection, but of all these good hand-washing is most important.

Infection control also includes a well-planned training program in which personnel can consider the why behind an infection as well as what should be done about it.

Modern units make it easier

Many of the changes in today's hospitals make infection control easier. Autoclaves, gas sterilizers, disposable equipment, new bacteria-resistant fabrics for blankets or staff clothing, or specially filtered air conditioning are examples. New agents for cleaning, skin scrubs, and germicides are being tested as well.

All of this is to no avail, however, unless it is properly used in the end. A dirty mop in housekeeping will offset the effect of a good cleaning agent. A single use, disposable item repeatedly used no longer carries the benefits it was designed for – and may even serve as a carrier for infection. A closed drainage system with a hole cut into it is no longer closed drainage. "Sterile" packages crushed and man-handled into a drawer may no longer be sterile.

Even a hospital designed to the best advantage for control of infections is to no avail unless the principle behind the design is understood and carried out.

Staff have done many things in the same ways for so long that they may find it hard to change, but the hospital

changing, the type of surgery is changing, and equipment is changing. There are many areas where the habits of the personnel must change, too. Hair may provide a reservoir for bacteria – which means complete hair covering may be needed in some areas besides the operating room. Constant movement stirs up bacteria-laden dust particles – which means that flow of traffic should be controlled, especially in high risk areas. Patients admitted to the hospital with an infection can unwittingly serve as carriers to other patients – which means that they need to be told of their potential danger to others. Uniforms and clothing worn outside the hospital increase the probability of bringing in infection – which means staff, especially those with the high risk patient, should change at the hospital.

Medical as well as nursing staff and other personnel must realize that they each play a role in microbial dissemination.

Constant surveillance needed

At the Ottawa Civic Hospital, an Infection Committee meets every month to discuss infections occurring during the month, problems that may be arising, or any changes to be made. Day-to-day surveillance is done by the medical bacteriologist, the director of health service, and an infection control officer.

Surveillance consists of case finding and hospital monitoring. Case finding means actually looking for any possible infections in the hospital by having the bacteriology department report all infections to the infection control officer, checking the elective and emergency surgery list, and checking the diagnoses of patients admitted to the hospital. Even more important are the routine visits to the head of each department. Cooperation, including reports about infections, is thus ensured.

Screening procedures for infection are also carried out for staff. Through the Personnel Health Service, stool cultures are done routinely on all food handlers to check for the possible chance of a carrier. Mantoux testing is done on all negative tuberculosis reactors and chest x-rays are done once a year on all staff. All staff are encouraged to report infections to health service.

This way it is possible to have an overall picture of the types of infection in the hospital at any given time.

Hospital monitoring means doing bacteriological surveys of different hospital departments, such as kitchen and operating rooms. There are two types of monitoring, one is routine sampling and the other involves a series of samples from a specific area to search for the solution to a specific problem.

Bacteriological sampling can indicate constant trouble spots, such as hard to clean areas, and can demonstrate the efficiency of the present methods of cleaning. When evaluating cleaning measures, it is important to realize that many extraneous factors may effect the result. Environmental sampling cannot be related directly to infections except in rare and atypical cases. However, it can be used to improve operational practices and to attain the lowest contamination level possible.

To isolate or not

Infections may be epidemic or endemic. Some infections, such as infectious diarrhoea, or any communicable disease, such as measles, should call for immediate action and isolation for the patient. The hospital population would be watched for other cases to develop, as this might signal the start of an epidemic.

Other infections, such as wound infections, are watched over a period of time to see if there is any indication of an endemic pattern. If the same organism keeps reappearing in a certain area, immediate action is needed to try and find its source and to clear up or remove the reservoir.

Isolation procedures need not be rigid, all-or-nothing routines. Many different organisms cause infections, and, as well, different grades of infection occur. It would seem best to grade the isolation procedure also, and correlate it with the infection.

Complete isolation would be used for the patient with, for example, a communicable disease, infectious diarrhoea, or grossly contaminated burns. This would mean that everything going into that room would need to be decontaminated before being brought back into general use.

Separation would be used for the patient with, for example, an infected wound. Care could be given in the general ward or in a single room if one is available. Everything coming in contact with the wound would be contaminated. This procedure requires complete understanding by the personnel caring for the patient as well as by the patient himself.

Reverse isolation would be used for highly susceptible patients, such as the recipient of an organ transplant, the uninfected burn patient, or a patient with a low blood count.

The need for isolation also depends on chemotherapy. The patient with a *group A beta hemolytic streptococci* infection responds rapidly to treatment with pencillin and the chance of cross infection is lessened. The tuberculosis patient responds to treatment with Isoniazid, which again lessens the chance of cross infection.

Conclusion

Increased awareness of the problem of infection in hospitals, more knowledge about how infections are caught and how they are spread, wise application of the advances in hospital technology, constant surveillance, and adequate treatment for infections are the goals of infection control.

The hospital is a complex community requiring the help of many people to keep it functioning. Infection control committees can help, but infection control really depends on the cooperation of each individual.

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idea exchange

A "Two-Way" Street

Over the past years, there has been a great deal written and said about the contributions which the hospital pharmacists can make to nursing education and nursing service. This is true, particularly in the area of pharmacology, which would cover such topics as therapeutic agents, adverse drug reactions, metrology, and preparation and administration of drugs – but what of the contributions nurses can provide to hospital pharmacists?

At St. Michael's Hospital in Toronto, the Department of Pharmaceutical Services holds weekly staff conferences and it was such a meeting that gave birth to the idea of nurses lecturing to pharmacists. The pharmacists themselves recognized their lack of knowledge in so many areas which go to make up a nurse's "day."

If pharmacists are to play an active part in the team, then an intelligent approach is to recognize that they may not know the situation as it exists "up on the nursing units."

Some hospitals have begun programs of "clinical pharmacy," which will be the answer to many problems, however even before the pharmacists can function in a clinical pharmacy setting, they should have a basic knowledge of nursing procedures, policies, and work-load.

At St. Michael's Hospital, when the director of nursing service had given approval to the tentative plan, the nurse-coordinator of special projects, Dorothy Shamess, went to work with the pharmacists and head nurses to set up the educational program. Miss Shamess met with pharmacists and discussed the areas in which they were interested. These were used as a basis for the program.

Even recent graduates from schools of pharmacy have very limited knowledge and experience in actual nursing procedures; the same holds true for those pharmacists who, after spending some time in the community pharmacy, have entered the field of hospital pharmacy. There is a trend, however, to include clinical pharmacy in the medical science complex of universities, and the day may not be too distant when pharmacy students will join with medical and nursing students in the hospital wards for a more



Sister St. Matthew, supervisor and instructor of the Urology Unit, assisted by Miss Mulcahy, head nurse, explains to the pharmacy staff principles of irrigation and dialysis.

meaningful course in clinical work.

Choice of subjects

At St. Michael's, the following topics were chosen as material to be included in the inservice course for the pharmacists: colostomies, bladder irrigation and catheterization, peritoneal dyalysis, treatment, including compresses, of bed sores and ulcers, tube feedings, and charting.

Lectures were given weekly, on Tuesdays and Thursdays – each lecture being repeated so that all pharmacy staff could attend. Initially the lectures were 30 minutes in length, but as the program developed the lectures were extended to one hour.

Miss Shamess organized all the lectures and demonstrations and the pharmacy department was notified of the arrangements on a weekly basis. The form of the presentation varied with the topic but in general it was a lecture, which covered anatomy, physiology, etiology, and treatment, followed by a demonstration at the bedside of the patient. At the lecture on dialysis a film was shown, giving a further explanation of peritoneal dialysis. The lecture on charting included information on the specific sections of the chart, the use of medicine tickets, and the Kardex.

The enthusiasm, not only of the pharmacy staff but also of the nursing staff was most encouraging to see as this program proceeded along its scheduled outline. Several of the nursing units cooperated in this joint venture and were pleased that they could help. Classrooms on the units were made available to our "students," the patients were prepared, and the nursing staff present to assist us.

Pharmacists now have a better understanding of the techniques and procedures used on the nursing units. This program has also provided an opportunity for nurses to share their knowledge and problems. Nurses and pharmacists have come to know each other better and have taken a good hard look at their common "raison d'être" – the care of the patient. – Sister M. Liguori, Director of Pharmaceutical Services, St. Michael's Hospital, Toronto.



Miss Archer, nursing student, demonstrates the technique of dressings to five pharmacists during a special course in which pharmacists learned about nursing.

Resources and use of CNA library

The resources and services of the Canadian Nurses' Association's library support the Association's studies and consultation programs, and supplement the local library facilities that are available to members.

Margaret L. Parkin, B.A., B.L.S.



CNA librarian Margaret Parkin adds a nursing cap to the display in the library's archives collection.

Why an article about libraries and library service, written by a librarian, in a nursing journal? Well, for many reasons.

For one, nurses – in common with persons in all professions and many trades and occupations – have found that libraries are an integral part of their educational process, whether this education is undergraduate, graduate, or continuing. And, in today's world of rapid technological advances and sociological change, education *is* continuing and essential for the practice of any profession.

Also, it has been customary in recent years to devote a page or two of the March issue of THE CANADIAN NURSE to libraries. A week in March used to be designated "Canadian Book Week," and many of us regret that this practice was discontinued, even though it can truthfully be said that *every* week is "Book Week."

Finally, the CNA library is now in its fifth year of service. Although its resources and services have grown rapidly and are well used from coast to coast and around the world,* there are still those who ask "How do we use the CNA library?" "What services does the CNA library provide?"

*In 1968, some 3,000 items were borrowed from the library, 1,200 reference requests were processed, and more than 2,500 copies of bibliographies were distributed.

Miss Parkin is Librarian, Canadian Nurses' Association, Ottawa, Ontario.

What is library service?

To repeat the definition used in these pages in March 1966, a *library* is a collection of books, periodicals, documents, and other printed, written, or audiovisual materials systematically organized and made available for use. The "use" may be recreational, educational, or informative. The *librarian* is defined as a custodian and purveyor of library materials; she is liaison officer between the library materials and the library users. The "users" vary from the population of a city who use a public library, faculty and students who use a university library, and members, students, or researchers of a profession who use a library such as the one at CNA House.

How are library materials made available for use? Many people are convinced that librarians gather all kinds of useful information and materials and hide them away so that only librarians can find them. They also believe that librarians want all the books in the library in tidy rows on the shelves. These people are, of course, wrong. The librarian's main objective is to make the library resources available for use. Her methods of achieving this objective vary, depending on the particular materials, their monetary value, and whether or not they need to be on hand for constant and ready consultation in the library.

Circulation and *reference* are the two basic forms of library service to users. They are basic to almost all libraries – public, university, industrial, and special – in varying degrees.

The circulation service makes items

available for users to borrow and to take away from the library for specified periods of time. The more items in circulation, the better is the library serving its users.

Directories, almanacs, yearbooks, encyclopedias, large or many-volumed dictionaries, atlases, and such material are generally made available by reference service. They may not be taken away from the library, since they are required for immediate consultation, either by the user directly, or by the library staff on behalf of users.

What are the CNA library resources?

A final preliminary to discussing CNA's library service is a brief outline of the library's role and resources.

The CNA library is a special library, a national nursing library. This role governs the selection of library materials, since its resources must include documentation and archive material about, or affecting, nursing and nurses in Canada, and nursing in other countries from which foreign nurses may come to Canada, or where Canadian nurses may serve. It is a research library rather than a teaching library. Nursing education and research, nursing service, and the economic and social welfare of nurses are emphasized and the holdings in the clinical areas are representative, rather than comprehensive. To support national office consultant and statistical services and the work of CNA committees, there are considerable holdings in sociology, statistics, labor relations, and higher education.

CNA's library has always been bilingual, with holdings in the English and French languages, catalogued in the language of source. The periodical racks at the entrance to the library, as well as those in the reading room, hold at least 75 journals with French titles; many other journals are bilingual. The reference shelf at the reading room door has French- and English-language reference tools, and all the shelves in the reading room are marked in both languages.

The first collection on the library shelves is the excellent series published by Les Presses Universitaires de France, the *Que sais-je?* series. It is very difficult to find French-language texts in nursing suitable for Canadian practice. However, many more clinical texts are purchased in the French language than in English, so that the faculties of schools of nursing can examine them and determine their suitability for use in Canada. Canadian government documents are either bilingual or are procured in both French and English editions. Two years ago, a mimeographed list of the library's French-language material numbered 155 items. There are considerably more now.

Returning to the collection as a whole, there are some 6,500 books and documents, classified in the National Library of Medicine** system. In addition, there are extensive vertical file holdings of pamphlets, newspaper clippings, and similar uncatalogued "short-life" material.

The library has about 350 periodical subscriptions, the majority of which are health science journals and news bulletins; a few deal with public relations, journalism, labor relations, and library science. About 50 journals of other national nursing organizations are received in exchange for either *L'infirmière canadienne* or THE CANADIAN NURSE Indeed, a major portion of the periodical collection is received on an exchange basis.

There are two special collections in the CNA Library. The *Archives Collection* contains documents and reports covering the history and activities of the Association, and books, documents, letters, photographs, and artifacts related to nursing in Canada. The *CNA Repository Collection of Nursing Studies* includes studies about nursing in Canada, or studies by Canadian nurses. In addition to reports by government commissions and departments, hospitals and other institutions and organizations, there are doctoral theses and papers written by students completing masters' degrees. This collection, which contains about 300 studies, is rapidly becoming a major resource for nursing research in Canada.

Associated with this collection, the CNA has prepared an *Index to Canadian Nursing Studies.* This index, which is presently being revised, covers studies in the same categories as the CNA repository Collection, but includes *all* studies that have been identified, not just those that are in the Collection.

The *Reference Collection* contains the usual language and medical dictionaries, directories, almanacs, encyclopedias, and university calendars. A large number and a wide variety of index and abstract journals are also found in this section.



The library has about 350 periodical subscriptions, most of which are health science journals and news bulletins.

**The National Library of Medicine in Washington, the major health science library in North America, was referred to recently as the "computerized central medical library in Washington" which CNA should emulate. However, as mentioned in the library article in the March 1968 issue of THE CANADIAN NURSE, the Canadian government has authorized a National Medical (essentially Health Science) Library, which is now developing under the auspices of the National Science Library.

These include Hospital Literature Index, Hospital Abstracts, Abstracts of Hospital Management Studies, the Glendale Cumulative Index to Nursing Literature, the International Nursing Index, Canadiana, the Canadian Periodical Index, the Canadian Education Index, Index Medicus, and the National Library of Medicine Current Catalogue. Reference resources also include biographical files on Canadian nurses, reports, bylaws and personnel policies of provincial nurses' associations, provincial and federal legislation affecting nurses, and data on nursing in other countries.

Audiovisual Resources are limited for many reasons. Audiovisual aids generally are designed to support specific education programs and thus are beyond the role of the CNA library at this time. Although a central library of audiovisual materials sounds desirable, the quantities required to support all Canadian schools of nursing would be extremely large. Such resources would be expensive to assemble, and a loan service also would be costly.

The CNA library does have catalogues of audiovisual aids from many agencies that are helpful in finding available materials. The library also has sets of slides prepared by the League of Red Cross Societies on nursing history. These slides are in almost constant use by schools of nursing. Copies of CNA-sponsored films are, of course, on deposit in the Archive collection, but the loan service is carried on by an outside agency.

Finally, mention must be made of that invaluable library resource shared by most libraries, the *Inter-Library Loan System*. This service is not limited to nursing, and is immensely helpful in extending an individual library's resources. The federal government's National Library of Canada on Wellington Street in Ottawa maintains a National Union Catalogue to which major libraries in Canada report their holdings. By means of this catalogue, material required for serious research and study may be located and borrowed on inter-library loan.

How is the loan service used?

Each month, a list of recent library accessions, that is, books and documents that have been added to the library holdings, is published in THE CANADIAN NURSE and *L'infirmière canadienne*. Near the accession list is a coupon that readers can clip out to request items they would like to borrow. These requests are filled as much as possible in order of receipt. Books and documents are sent out on loan for two weeks with provision for mailing time. The only cost to the borrower is the postage for return mailing.

Extension of the loan period can be requested; the request is granted, if absolutely necessary. However, prompt return of borrowed material ensures that as many borrowers as possible can have the material without waiting too long. Books and documents, other than accession list items, also can be requested by mail. If the required material is in the library's holdings, it will be sent on loan as soon as possible. If not, the CNA library, through the National Library of Canada, tries to find a library in Canada that has the material, and advises the would-be borrower.

As mentioned earlier, some categories of library material, reference, and archive items, must be used in the CNA library and are not available for loans outside CNA House. Studies from the CNA Repository Collection are loaned only on an Inter-Library Loan basis. Individuals ask their own institutional, public, or university library to obtain the required study for them. The borrowing library is then responsible for its safe custody and return. Periodicals are also in the "cannot leave CNA House" class. However, single Xerox copies of articles requested are supplied and a minimum charge is made to cover the operator's time and the paper used. Xerox copies of articles published in North American journals in the current year are not supplied since these, presumably, are still available from the publisher.

How is reference service used?

Users in the Ottawa area, and researchers and graduate students from out-of-town come to the library to use the reference resources, especially for extensive searches and studies. In addition, library staff give reference service by telephone and by mail. Reference questions range from addresses of schools of nursing and names of directors to lists of material on a topic or area of study.

A *bibliographic service* has developed as a result of these requirements for lists of reference material. Some 50 standing bibliographies have been compiled and are updated from time to time, depending on user demand. Many reference questions are answered by sending a bibliography. The user can then request any material of interest that is not available in a local library.

The library staff is small. Because of this, it is not always possible to do an extensive reference search immediately or to supply reference material by return mail. However, if there is a specific deadline for the material, every effort is made to meet it.

As in the case of loans, library staff search beyond the resources of the CNA library for information required for research and similar studies. Undergraduates are guided to sources of information instead of being supplied with data that is probably available in libraries in their own areas. They are encouraged to learn how to search and where to search.

Who uses CNA library services?

As indicated earlier, this library, located in the headquarters of the Canadian Nurses' Association, belongs to Canadian nurses. It is a library for CNA national office staff and the Association's membership everywhere across Canada and around the world. Its resources are used by nurses in public health units, hospital nursing services, by faculty and students in schools of nursing, by graduate students and other research workers, by consultants in government health departments, and by non-Association members with a need for information about nursing.

Are consultation services available?

The CNA library is not, as mentioned earlier, a teaching or clinical library. Its resources are intended to supplement, not to replace, library facilities available to nurses in their working or learning situations.

Every encouragement is given to librarians who hope to establish and develop good library resources for nurse practitioners and nursing education. This encouragement is provided by giving consultative service by mail, or through library orientation sessions to the librarians, who are generally non-professional. Last year, 14 day-long sessions were given at CNA House. The CNA librarian was senior resource librarian for two, five-day workshops for non-professional librarians, sponsored by provincial nurses' associations in the Maritimes and in the Prairie provinces. □

Canada's rare blood bank

With the increase in the number of blood transfusions in the past few years, some extremely rare blood types have been identified. The Red Cross and the National Defence Medical Centre have both a file on and a storage unit for these rare types. This article describes this service.

Len Carter

In a hospital in Singapore in August 1968, a Gurkha soldier serving with the British forces lay seriously injured. He needed a blood transfusion to save his life.

But the type of blood he needed was very rare. Called Bombay O_h, it was discovered in the Bombay, India, area in 1952, and even there its incidence is only one in 13,000. In Caucasians it is extremely rare.

A distress signal went out to the World Health Organization. A check of the International Rare Donor File of that organization revealed that the only Bombay O_h available was stored at Canada's rare blood bank at the National Defence Medical Centre in Ottawa.

The emergency call was relayed to Canadian Red Cross headquarters in Toronto, which in turn notified the rare blood bank in Ottawa of the critical situation. That evening the only two units of Bombay O_h stored in the bank were on their way to Toronto in a container surrounded by tins of ice and packed in a heavy duty cardboard box. The next morning it was flown to Tokyo and from there to Singapore.

Some while later the Red Cross reported that the Gurkha soldier had pulled through nicely, thanks to Canada's rare blood bank and to an anonymous donor in St. John's, Newfoundland, the only registered donor of this rare blood type in Canada.

Only the "very rare" types

The Bombay O_h that saved a life halfway round the world is only one of 30 extremely rare blood types deep frozen at Canada's only rare blood bank, in Ottawa. These rare types include one from a donor whose blood type is at present the only one of its kind known.

Concrete plans for the rare blood bank began in April 1964, although experiments had begun as early as 1962. Plans involved the National Defence Department, the National Health and Welfare Department, and the Defence Research Board. The project, an outcome of a study on the military application both of rare blood types and of freezing blood for storage, was completed in January 1965. In August 1966 the National Defence Medical Centre was officially designated the rare blood bank for Canada, jointly involving the National Defence Department and the Canadian Red Cross Transfusion Service. The blood bank is under the direction of Dr. R.K. Smiley and Dr. W.J. Wills.

By mid-September of that year there were 24 units of rare blood in storage. At present, there are approximately 80. The storage unit can handle 125.

The Medical Centre handles the processing and storage while the Red Cross acts as the supply and issuing agent. Red Cross depots across the country file the names of Canadians found with rare blood. All these names are then catalogued at the Society's head office in Toronto and it is decided which blood types are rare enough to ask for a special collection for storage, either for possible world-wide use or for personal use in an emergency or during elective surgery.

Units (500 cc.) of those rare enough for banking are collected by the Red Cross and are sent to the bank – usually by air – to be processed for deep freezing.

Donations of blood of more common types are stored at just above freezing at the local depots and must be used within three weeks; deep frozen blood may be kept as long as five years or even longer, but at present deep freezing is too expensive for anything but the rarest types.

Rare blood sent anywhere in the world or Canada is released through the Red Cross's Toronto office.

To date, people with blood rare enough for collection have been found in all but three provinces. For instance, there is an Indian living west of Edmonton with an extremely rare type, which Dr. Biro calls –D–, –D–. Part of a chromosome in this man's blood cells is missing.

The Red Cross's national rare blood file recently proved its value when four pints of one of the rarest blood types in the world were needed to save the life of a newborn baby girl in Oshawa, Ontario. Two women in Nova Scotia and one in Northern Alberta were known to have the same blood type according to Red Cross files; they combined through their blood donations to help save the life of the infant.

Special process for long-term storage

At the rare blood bank, the key piece of equipment used in processing blood for freezing and later reconstitution is the

Mr. Carter is a medical reporter for *The Ottawa Journal* and a freelance writer, and has three stories currently under production with the Canadian Broadcasting Corporation.



Warrant Officer B.S. Wambolt prepares a pack of red blood cells for freezing at the National Defence Medical Centre's rare blood bank. Warrant Officer Wambolt reconstituted the rare Bombay O_h blood that was shipped to Singapore last August to save the life of a Gurkha soldier serving there.

Huggins Cytoglomerator. It was developed by Dr. Charles Huggins, a professor of surgery at Boston's Massachusetts State Hospital.

Priced at about $10,000, it is the only one in Canada and as far as is known there are only four or five others in the world. Two are being used in Vietnam and another aboard a specially equipped United States destroyer.

The Cytoglomerator separates off plasma, leaving about 300 cc. of cells. These cells are put in a plastic sleeve about three feet long and mixed with a glycerol solution; the cells can then be frozen without damage.

The suspended cells are then spread along the length of the sleeve, which is folded and placed in a carton. The carton goes into the deep freeze unit at minus 85 degrees centigrade – the temperature of dry ice or four times as cold as a home freezer.

When an emergency call comes in for a certain type of blood on hand, the frozen cells are thawed at 40 degrees centigrade and put back on the Cytoglomerator – which can handle five units at a time when necessary – where the cells are cleansed of the protective glycerol solution by washing them three times in a sugar solution.

The final step is to suspend the cells in a saline solution – or in the original serum, which also can be frozen – and bag the results in a plastic pack connected to the original sleeve. The pack is used to administer the transfusion. Frozen cells can be reconstituted for shipment in 40 minutes.

Finding rare types

Dr. Biro explained that many people think they have quite ordinary blood types according to the two primary methods of blood typing, and may not discover otherwise until they either donate blood or enter a hospital for surgery. The two primary methods of blood typing are the ABO system, first described by Landsteiner in 1900, and the D factor typing, which gives the Rh positive or negative reading.

At Red Cross donor clinics, according to a senior technician at the Ottawa donor clinic, whenever they discover a D negative reading, they also check to see if the donor is negative to two other factors – C and E.

However, says the technician, it is more often that a person discovers he or she has a rare blood type through the extensive cross-matching done in a hospital prior to surgery.

Only this cross-matching process, either major or minor, searches out blood type rarities. The minor cross-match detects antibodies in the serum of the donor's blood that are capable of effecting the recipient's blood cells. As the donor antibodies are greatly diluted by the recipient's plasma, however, they are considered of "minor" importance. The major cross-match is the more important of the two because it detects antibodies in the serum of the recipient, which may damage or destroy the red cells of the proposed donor.

Medical science says there is no positive reason for blood rarities other than genetic variation and the fact that blood types are not restricted to any particular race.

Blood type rarity, Dr. Biro says, depends on the presence or absence of antigens on the red cells. The antigens build up antibodies in the blood serum against donated blood unless the red cells of the donated blood have identical antigens.

Once a person discovers he has an extremely rare blood type, he should consider donating blood to the Red Cross and having it stored against the day when a transfusion might be needed. An Ottawa doctor with a rare blood type has a bleeding ulcer; he has donated blood to the Red Cross and it is deep frozen as kind of an insurance should he hemorrhage or require surgery for another reason.

However, in most cases there is no guarantee that your rare blood type may not be shipped out in answer to an emergency call to save a life in the Outer Hebrides before you require it.

Frozen blood more useful

The value of deep freezing is not limited to preserving rare blood types for long periods. Reconstituted, deep frozen blood of any type survives better in the body of the recipient when transfused. Freezing suspends the aging process – each day 1/120th of our red blood cells die and are replaced by new cells – and frozen blood when transfused even years later is as fresh as the day it was collected.

According to Dr. Biro, there is a greater safety factor in frozen blood. For instance, hepatitis, a virus infection of the liver, can be transmitted from one person to another through transfusion of blood stored in the normal manner. Frozen blood, Dr. Biro says, eliminates this and other hazards.

Because there is less reaction to frozen blood, he would like to see it used in critical transfusions. Frozen blood has been used extensively in organ transplant surgery to reduce the possibility of rejection.

It is very likely that when the deep freezing process has become less costly and less time consuming, all future blood donations will be deep frozen until needed for transfusion. One of the many advantages will be to eliminate the crisis often faced by hospitals when there is a shortage of donor blood. □

A dollar, a dollar, follow the scholar

Last May, THE CANADIAN NURSE presented an article about Dorothy J. Kergin a 1967 recipient of Canadian Nurses' Foundation funds who was studying for the doctor of philosophy degree at the University of Michigan in Ann Arbor. Now, almost a year later, the editor of CNJ "follows the scholar" to her new home in Dundas, Ontario, and to her place of employment, McMaster University's School of Nursing in Hamilton, and talks to her about her responsibilities as associate director of nursing.

V.A. Lindabury

Dr. Dorothy Kergin, in plaid slacks and a comfortable-looking ski cardigan, pointed out various landmarks, including McMaster University, as she drove us from the airport limousine depot in Hamilton to her apartment in Dundas. It was a bright Sunday morning in midwinter, and Dorothy's pleasure at living in this small suburban community, two miles distant from the university, was evident.

"We even have a mountain here," she said, referring to the 250-foot-high Niagara escarpment – known affectionately by the natives as "The Hamilton Mountain." "And we're far enough from the city to avoid the usual traffic problems, yet close enough to allow us to take advantage of the amenities of city life," she added.

Dorothy settled into her Dundas apartment and her role as associate director of McMaster's School of Nursing early last September, after completing a three-year doctoral program at the University of Michigan in Ann Arbor. She received her Ph.D. degree in December, and admitted that the ceremony was one of the most exciting experiences in her life. "My friends tell me that I really 'lost my cool' on graduation day," Dorothy chuckled, "because I kept asking where my car keys were – as I clutched them in my hand! "

Most of Dorothy's nursing career before attending the University of Michigan was spent in public health in her home province, British Columbia. (Readers will remember Dorothy as the public health nurse with a rather unusual reputation: when stationed at Princeton, B.C., she went routinely to the Copper Mountain mining area in her district "in search of disease and affection" – a quest accorded her by an imaginative young Copper Mountain schoolboy in his essay on "What the Public Health Nurse Does When She Comes to Town.")

Three main responsibilities

"I have three main responsibilities at McMaster," Dorothy explained, as we sat in her modern, eighth-floor apartment sipping our second cup of strong coffee. "I teach public health nursing and coordinate the students' clinical practice in public health; serve as associate director of the school, working with Alma Reid, the director; and have some responsibility for research. Actually, I haven't had time as yet to even think about research," she added, "but I hope to remedy that in March, after my teaching responsibilities are over for the year."

Until mid-December, Dorothy taught public health nursing theory to the 28 students in the final year of the basic baccalaureate degree program in nursing, and supervised the activities of 10 of these students in the Hamilton-Wentworth Health Unit. Her lectures ended in December, and she and her students spent considerably more time in the clinical setting in January and February.

When not teaching, Dorothy usually can be found at a committee meeting. One committee she is on meets regularly to make plans for the new school of nursing, scheduled to open in the fall of 1970. "Our school will be part of the Health Sciences Center," Dorothy explained, "and will be housed in the new University Hospital, along with the medical school. We'll probably be able to more than double our yearly student enrollment, which is now limited to 30 because of lack of facilities."

Dorothy is chairman of an interdisciplinary committee set up to explore opportunities for joint activities for student education, and to clarify some of the role relationships among members of the health professions. "These meetings are quite stimulating," she said, "probably because each representative from nursing, medicine, and social work has a different idea about the proper role of persons on the health team, and isn't afraid to voice it."

We asked Dorothy what other responsibilities she had at McMaster.

"Well, I'm in charge of public relations for the school of nursing," she said, "and in future will be working closely with the Health Sciences Center's new public relations officer. As part of this, one of my responsibilities this year is to update the school of nursing's calendar."

This year, Dorothy is helping to make arrangements for nurses from abroad who wish to visit McMaster University School of Nursing before attending the International Council of Nurses' Congress in Montreal in June. "We're working closely with the Registered Nurses' Association of Ontario and schools of nursing in Hamilton in planning a short program on nursing education immediately prior to ICN," she said, "and we'll probably be arranging visits for a few nurses after the



Dorothy Kergin (center) looks at the architect's plans for the new Health Sciences Center, with Alma Reid (right), professor and director of McMaster School of Nursing, and Henrietta Alderson, associate professor.



Weekly seminars are held so that students can discuss problems they have encountered in giving public health care to the families assigned to them. This seminar is chaired by Dr. Kergin.

Congress."

In her spare time, Dorothy is writing part of a chapter for a book that will be published by the University of Toronto School of Nursing to commemorate its 50th anniversary in 1970. She will incorporate some of the findings from her doctoral thesis into her writing.

Enjoys the university "atmosphere"

As we ate lunch, Dorothy talked about her life as a faculty member, reminding us that this was her second experience at university teaching. Immediately before embarking on her doctoral program, she had taught public health nursing at the University of Michigan.

"It's stimulating to work with students at this level," she said. "You really have to be on your toes and keep up-to-date with everything. I came to this school, which offers a basic baccalaureate program, because I believe the graduate of such a program is the foundation upon which we should be building our profession.

"And I enjoy the university atmosphere," Dorothy added. "There are plenty of educational opportunities here that staff can take advantage of, such as various lecture series, and it's interesting to be associated with people in other disciplines who have similar interests in education, yet different backgrounds and points of view."

Dorothy said that her doctoral program has given her considerable understanding of the organization of universities and the relationships and responsibilities that exist within the university structure. "When certain things happen here, I can think back and see the rationale for them, so in this way the doctoral studies were helpful. In another way, just the broadening of one's background and understanding of other disciplines – sociology and psychology, for example – is extremely helpful to any teacher.

Enthused about CNF

Dorothy is a staunch supporter of the purposes of the Canadian Nurses' Foundation. As she told us before, she could not have stayed at school to complete her doctoral degree, if she had not received financial assistance from CNF.

When we reminded Dorothy of CNF's financial plight (to date, only $25,000 is available for 1969 fellowship awards, less than half the amount awarded in each of the past two years), she suggested that the present two-dollar membership fee should be increased. "Personally, I would have no objection to paying a larger fee," she said, "and I think that most people who are members, who are committed to the concept that there should be a Canadian Nurses' Foundation, will continue to support CNF, even if the membership fee is increased.

"Why not publish an article on wills and bequests, and put a bequest form for CNF in THE CANADIAN NURSE? Dorothy asked. "This might encourage nurses to will money to the Foundation. Too often, women don't bother making wills, because they don't have families."

Dorothy also believes that the federal government must be convinced of the need for more traineeships for nurses. "I believe that, in future, lobbying will be an important role for the Canadian Nurses' Association," she said. "A full-time CNA lobbyist would be able to keep the government informed of the Association's viewpoints, and could also keep the nursing profession aware of pending legislation and its implications for nursing."

Back with people

Last year, when Dorothy was completing her dissertation for her doctoral degree, she felt rather isolated, because the demands of her studies cut her off from her usual contacts with friends and colleagues. This year, she is back with people and enjoying it. And we have a strong suspicion that the people Dorothy works with are more than pleased to have this former CNF scholar in their ranks.

Membership in the Canadian Nurses' Foundation can be obtained by sending your name, address, and cheque for two dollars to: CNF, 50 The Driveway, Ottawa 4. Donations in addition to the two-dollar membership fee are, of course, welcome. Membership fee and donations are tax-deductible. □

New services help patients and staff

A description of two new services — a day nursery for the children of the hospital staff and a consultation clinic for outpatients — at Montreal's Santa Cabrini Hospital.

Nicole Beaudry-Johnson

To attract married women back to nursing, some hospitals in Canada have set up their own day nurseries to care for the children of members of staff. The *Jardin Cabrini,* at the Santa Cabrini Hospital in Montreal, is the first such day nursery to be set up in the Province of Quebec.

Reverend Mother Sylvie of the Missionary Sisters of the Sacred Heart, the present superior of Santa Cabrini Hospital, says that the day nursery relieves the working mother of many worries concerning the care of her child. The mother's worries about leaving the child with an unknown babysitter, a neighbor, or a relative are eliminated; she knows, too, that the child will receive prompt treatment if he becomes ill.

Everything scaled down

The day nursery occupies large quarters close to, but outside, the hospital's center of activity. Everything is scaled down to a child's size so that furniture, drinking fountains, and bathrooms are the right height for the child's comfort and protection. Even the elevator has been installed without buttons so that even the most imaginative child cannot operate it alone. A dining hall, a dormitory, a playroom, a classroom, an infirmary, and a small waiting room for the mothers are included in the day nursery complex.

For a modest weekly fee, the tots spend their day under the same roof as their mothers and receive the same care as they would in the more expensive, private day nurseries. Four competent attendants – a nursery school teacher, a nun, and two assistants – look after their needs. The nursery school teacher works from 9:30 to 11:30 a.m. and from 2:00 to 4:00 p.m.

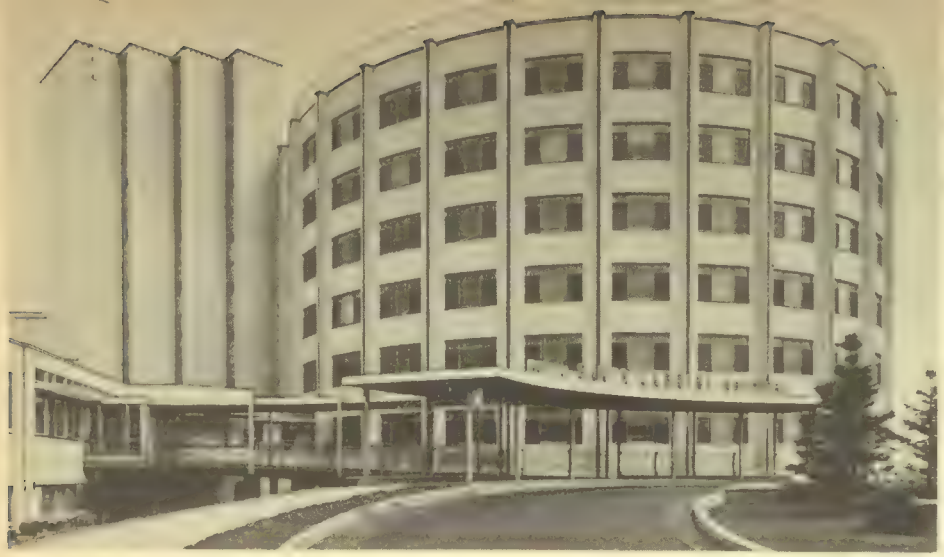
The children enjoy music, painting, singing, handicrafts, and, in summer, various games that can be played outside on the hospital's large stretch of lawn. They get a hot meal at noon and two snacks during the day. After dinner, they have a rest period.

Toddlers are admitted to the day nursery as soon as they are toilet trained, and can attend until they are six. On registration, all children are seen by a doctor. The mother can bring her child in as early as 7:30 a.m., and can leave him until 5:00 p.m., giving her time to shop if she wishes.

Increase in services

When the day nursery opened its doors in September 1968, there were 40 registrations. Mother Sylvie expects the number to increase, and says she hopes the service will soon be available for school-age children. These children would get their noonday meal at the day nursery and would return there after class to wait for their mothers. Mother Sylvie also expects that the nursery will be able to accommodate the children of other working mothers in the neighborhood in the near future.

Mme Beaudry-Johnson is Associate Editor of *L'infirmière canadienne.*



Santa Cabrini Hospital, designed by the Italian architect Pellegrino De Sina, is one of the most modern and best-equipped hospitals in Montreal.

Consultation clinics

Santa Cabrini Hospital's outpatient clinic, which opened last July, operates on the same principle as a doctor's office, and offers all the advantages of the available hospital services.

Patients come to the clinic on appointment, thus eliminating the long waiting periods that are so typical of most hospital outpatient departments. According to clinic coordinator Dr. John Xenos, most patients who come to the clinic are without a family doctor or, having seen a doctor, are dissatisfied with the results. Many patients are immigrants who do not know where to go for medical assistance. An interpreter, who speaks several languages, helps these people to communicate their problems to the doctor. The clinic seems to be a success, as the number of patients attending has tripled since its opening.

Primary contact

The new clinic is composed of many units, including prenatal clinics, clinics for dental surgery and ophthalmology, orthopedic, cardiology, and internal medicine clinics, and a department of audiology.

A patient who attends the outpatient clinic is examined by the "primary contact" doctor – a general practitioner – who sees him again or refers him to a specialist according to his need. Four general practitioners are on duty from 8:30 a.m. to 3:30 p.m. Monday to Friday. Specialists are on rotation duty, and each day of the week is reserved for consultations in a given specialty. Night calls, when urgent, are referred to the emergency clinic.

The primary contact doctor treats 65 percent of the patients, according to statistics made available by Dr. Giallo-reto, who is Chief of Staff and in charge of medical teaching at Santa Cabrini Hospital. If a patient is referred to a specialist, he later returns to the primary contact doctor for further care.

Nurse's role

Irene Pelletier, assistant head nurse at the outpatient clinic, explained that the nurse's main role in the clinic is to welcome the patient and calm his fears. "For some reason," she said, "the patient generally feels more anxious than he would if he had gone to the doctor's office. The surroundings are new to him. We must be smiling, calm, and patient."

There are three nurses on duty at the outpatient clinic. According to Miss Pelletier, their work is similar to that carried on in a doctor's office. "We record the patient's weight and height, chart his vital signs, and take blood samples for laboratory analysis.

The clinic nurses make certain that the patient's records are complete, and make a follow-up appointment for him. If the patient is in financial difficulties, the nurse refers him to the department's social worker; otherwise the patient pays for his visits. □



The hospital's day nursery relieves the working mother of her worries about the welfare of her child.

books

Nurses Can Give and Teach Rehabilitation 2nd ed., by Mildred J. Allgire, R.N., R.P.T., M.A. 93 pages. New York, Springer Publishing Company, Inc., 1968.
Reviewed by Charles Ball, Director of Nursing, The Perley Hospital, Ottawa, Canada.

The second edition of this book, written primarily for those engaged in the care of the handicapped, is presented in a style that makes it easy and enjoyable to read.

For those who need to be convinced of the values of rehabilitation, there is a very good introduction. This is followed by short but informative chapters on the prevention and treatment of complications in the chronically ill, emotional problems in patients with chronic disabilities, and nutrition in rehabilitation.

A welcome addition to this second edition is the chapter on bladder and bowel training.

A major portion of the manual is devoted to physical rehabilitation nursing care. General information is given on bed posture, and 16 basic exercises are described and illustrated. The importance of assigning only exercises that meet the individual patient's needs is stressed and the necessity for patient activity is clearly demonstrated. Rehabilitation in the home as well as in hospital is discussed.

This manual would assist the student in understanding the role of the nurse in rehabilitation.

Sex and Its Problems edited by William A.R. Thomson, M.D. 90 pages. Edinburgh and London, E. & S. Livingstone Ltd., 1968. Canadian agent: Toronto, Macmillan Co. of Canada, 1968.
Reviewed by Dr. S.R. Laycock, Vancouver, B.C.

This book, designed to help the family doctor in his understanding of sexual problems, contains a series of 12 articles written by medical men in Britain and published in 1967 in the British periodical *The Practitioner.* The topics discussed include: sexual problems of adolescence, the impotent male, the frigid female, infertility in the male and female, artificial insemination, sexual adjustment, and the climacteric and medical aspects of homosexuality and sexual perversion.

The articles are, on the whole, very readable. Unfortunately, the two most technical articles are the first in the book and are likely to discourage the non-medical reader.

The book is of special value to medical students, general practitioners, student nurses, and graduate nurses. The intelligent layman would find the book informative.

Urology for Nurses by J.P. Mitchell, T.D., M.S.(Lond.), F.R.C.S., F.R.C.S. (Edin.). 324 pages. Toronto, The Macmillan Company of Canada, 1968.
Reviewed by Frances M. Cochrane, Nurse-in-charge, Cystoscopy Room, Royal Columbian Hospital, New Westminster, British Columbia.

This book is an excellent guide to the surgical aspect of urology. It is of interest not only to nurses working on a urological ward or in a cystoscopy clinic, but to orderlies working with nurses in these areas. Detail about surgical operations and instruments has been amplified to cover the needs of the operating theatre staff. The size of this volume does not permit discussion of subjects such as nephritis or venereal disease, neither of which is now regarded as the responsibility of a nurse working in a department of urology.

Although the art of nursing is largely one of practical application, it is always a helpful stimulus to know the reason for the various treatments prescribed and the operations performed. Furthermore, in these days when the limits of our knowledge are extending so rapidly, frequent changes in methods of treatment will occur. Sometimes these changes may even appear to be a paradoxical reversal of basic principles. It is with this concept in mind that a certain amount of theory has been presented in this book, theory that may at first appear to be unnecessary for a nurse's education. Recent advances, such as the treatment of acute renal failure by dialysis, are described in some detail. More practical features, such as the management of a cystoscopy clinic, are also described in the belief that urology will develop as a specialty in most hospitals within the forseeable future.

To the nurse who is interested in why and how complicated investigations are done, to the nurse who wants a detailed guide to a cystoscopy clinic, or to the nurse who simply wants to learn the proper way to test urine, this book will be invaluable. The author has included every important detail while reducing theory to a minimum. He preaches simple common sense based on accurate knowledge.

This book is well illustrated with halftone illustrations and photographs. It is especially valuable because of the limited number of books available on this topic for use by nurses.

Nursing Care in Eye, Ear, Nose, and Throat Disorders, 2nd ed., by William H. Saunders, B.A., M.D.; William H. Havener, B.A., M.S. (Opth.), M.D.; Carol J. Fair, R.N., M.S., and Josephine T. Hickey, R.N., M.S. 402 pages. Saint Louis, Mosby, 1968.
Reviewed by Marcella MacDonald and Eileen Burgoyne, Eye, Ear, Nose, and Throat Department, Camp Hill Hospital, Halifax, N.S.

Section one contains 15 chapters on ocular disorders. Anatomy and physiology are discussed and an account of clinic examinations of eyes is given. The significance of various eye symptoms is particularly well covered and is followed by a brief account of drugs commonly used in the treatment of eye disease.

The chapter on nursing care is good and certainly outlines current ideas of postoperative nursing care and the use of ophthalmic preparations. Refractive errors, injuries, infections, strabismus, glaucoma, cataract, and retinal detachments are each given a chapter, and all the conditions are adequately explained and the treatment principles described.

A few of the less common eye diseases are described in Chapter 13. The last two chapters are devoted to the problems of blindness and attempts to dispel common misconceptions about eyes.

This section is easily read and well illustrated, and represents an excellent basic text for any nurse caring for eye patients. It is highly recommended and should be in every eye ward.

Section two is devoted to disorders of the ear, nose, and throat.

Anatomy and physiology, old and modern methods of medical and surgical therapy, and measures of prevention are explained clearly and logically.

The authors' extensive use of illus-



books

trations effectively clarifies and complements their pertinent information. It seems a pity, however, that Frank Netter's beautiful illustrations taken from *Clinical Symposia* have not been reproduced in color.

A glossary and a list of suggested and reference readings are also included.

Particular emphasis is placed on nursing procedures, patient teaching, and the physiological and emotional changes that the individual patient undergoes.

This text provides an authoritative background to enhance nursing performance and maintain it at a high level of clinical competence, which, as stated in the preface, is the authors' aim.

Storage of Blood by B.A.L. Hurn. 167 pages. New York and London, Academic Press, 1968.
Reviewed by Dr. D.M. Wrobel, Medical Director, Canadian Red Cross Blood Transfusion Service, Toronto.

This book brings a renewal of promise that the consolidated efforts of many scientists will establish long-term blood storage as a routine practice. As yet, there is no substitute for blood, and until there is it will always be regarded as a life-giving fluid. To fulfill its biological expectations, the red cells must be kept viable during storage.

In this book, the author gives precise, up-to-date information with many invaluable references and his own practical views on this fascinating subject. Each chapter opens yet another aspect of the blood transfusion. The author discusses with clarity the complexities of blood metabolism under various storage conditions, the effect of different anticoagulants and purine nucleosides in relation to biological and biochemical degradation. Even under ideal storage conditions the limited life of blood creates acute shortages from time to time; this reflects the urgent need for long-term storage. The author evaluates the different methods and techniques of freezing and thawing blood for transfusion purposes, together with its practical implications in clinical medicine. The last chapters of the book deal with methods of red cell preservation for routine as well as research laboratory.

A short review of the storage of other blood components – platelets, leucocytes, and plasma constituents – completes the book. Anyone who is in any way connected with blood transfusion, be he clinician, pathologist, technician, or nurse, should read this excellent book. It

is well-written, with enough clear details that the uninitiated reader will feel no stranger in this field. □

accession list

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Material on this list, *except* Reference items, including theses, and archive books, that do *not* circulate, may be borrowed by CNA members, schools of nursing and other institutions.

Requests for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50 The Driveway, Ottawa 4,

No more than *three* titles should be requested at any one time.

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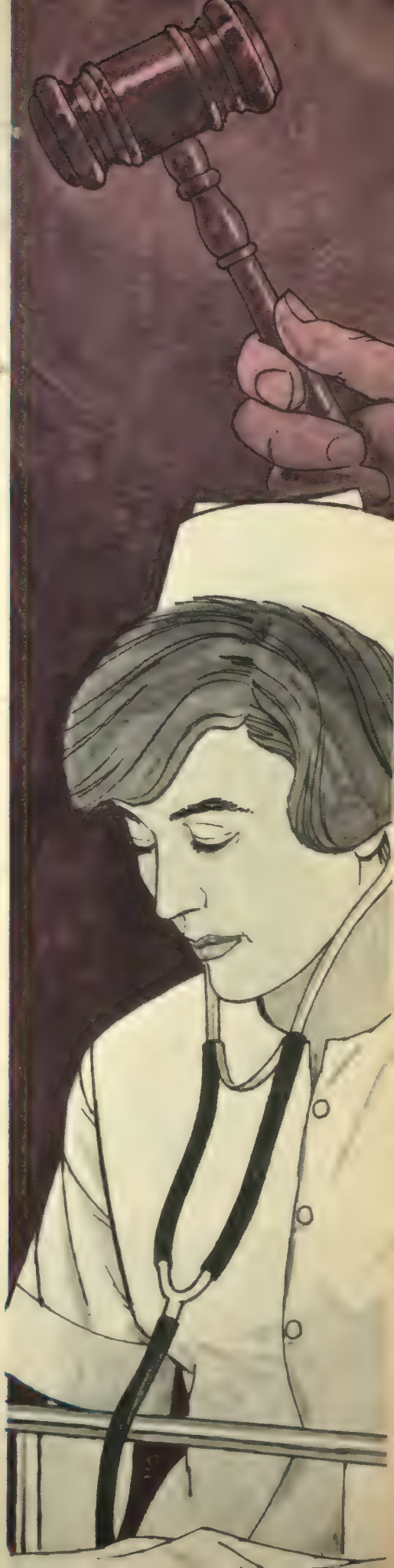
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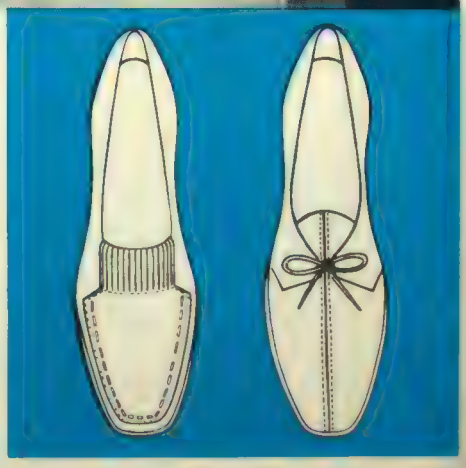


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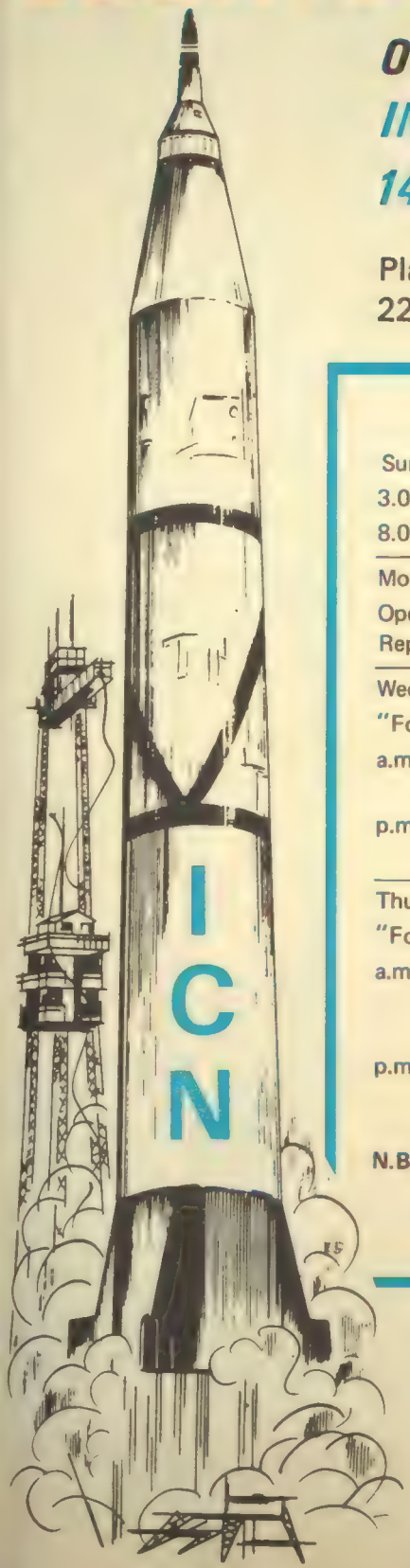


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Wednesday, 25 June
"Focus on the Future"
a.m. Plenary session —
Forecasting the Future
p.m. Plenary session —
Implications of Change

Thursday, 26 June
"Focus on the Future"
a.m. Plenary session —
Education for Today and Tomorrow. Basic Programs
p.m. Plenary session —
Education for Today and Tomorrow. Post Basic and Post-graduate Programs
5.00 p.m. Voting for ICN Officers by CNR
8.00 p.m. Students' Congress

Friday, 27 June
"Focus on the Future"
a.m. Plenary session —
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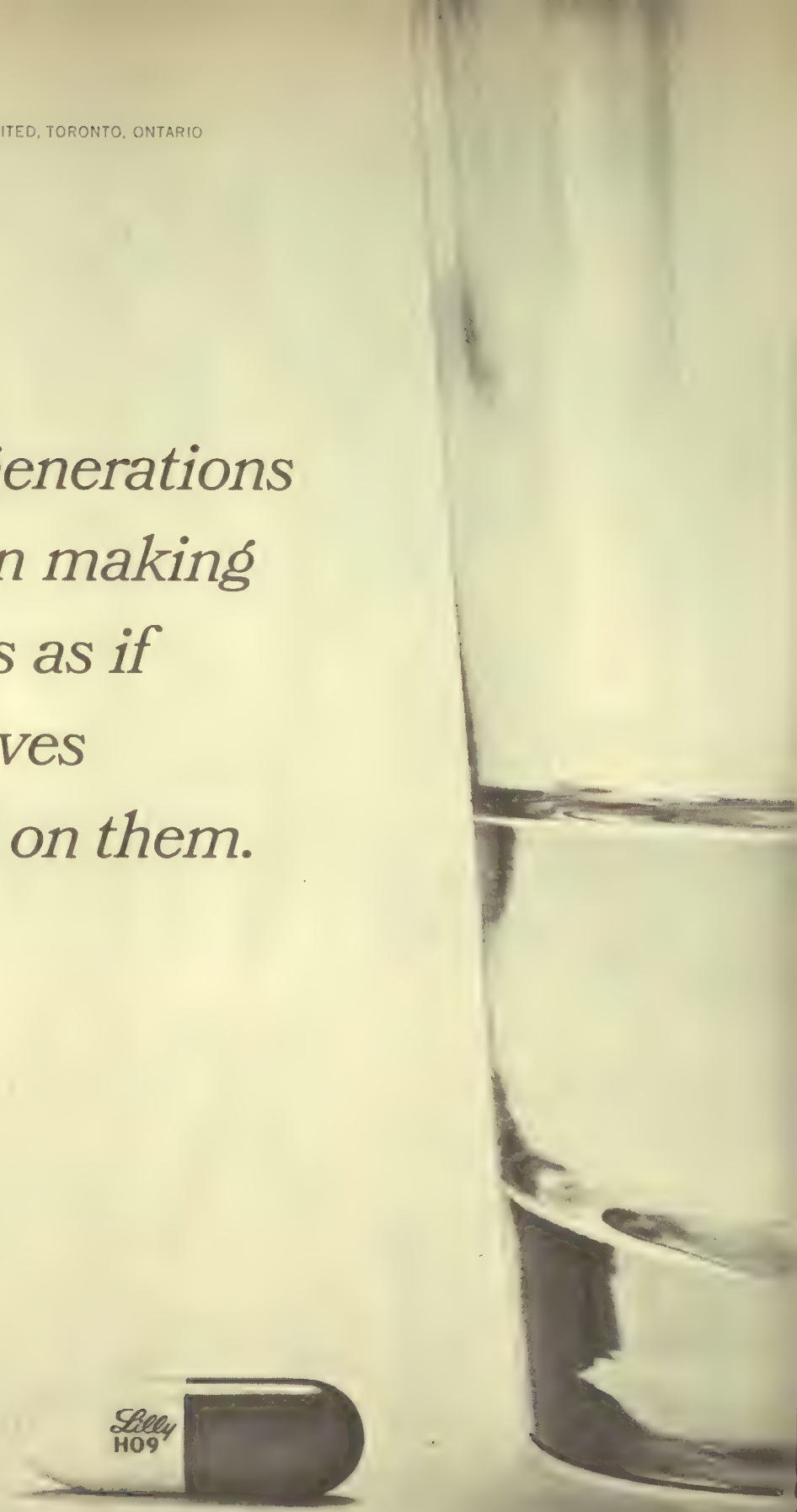
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Volume 65, Number 4 April 1969

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Editorial

The strike of 18 nurse educators employed by the Hamilton and District School of Nursing (News, page 7) will probably be ended and the main issues settled — in one way or another — by the time this editorial is read. Even so, we believe that certain aspects of this strike and the negotiations that preceded it need to be examined, because they have implications for *all* nurses.

Let it be understood that we support these nurse educators in their efforts to obtain fair wages, benefits, and working conditions. We are convinced that they had no other alternative but to take the action they did. They went on strike as a last resort, after they had met again and again with an employer who remained inflexible.

The experiences of these teachers raise several questions. First, how can collective bargaining be considered anything but a farce, when an agency such as the Ontario Hospital Services Commission — a government commission that is responsible to the minister of health — is in a position to pull strings so effectively that employers of nurses and nurse educators refuse to budge an inch from the salary directives it lays down?

Second, why, in this instance, does the employer say "We cannot meet their demands," and yet offer to submit the grievances to a government-appointed arbitrator, whose findings would be binding on both parties? The arbitrator might well recommend that the teachers be paid the salaries they are asking; it is even conceivable that he would recommend higher salaries than they are demanding.

This offer on the part of management is difficult to fathom. It gives the impression that the arbitrator — who is supposed to be impartial — might see things their way.

Our third question is this: Why did 2 of the 18 instructors, one of whom definitely voted in favor of strike action, become turncoats and return to work? If they didn't favor strike action, they should have voted against it; having declared their intention, they should not have abandoned their colleagues and their principles.

Our fourth question concerns the nursing students who, as future members of the profession and as future employees, may one day be faced with similar grievances. According to a *Globe and Mail* report, the students "took no side in the dispute," although "many students were friendly to the strikers."

We understand the concerns of these students who wish to see an immediate settlement. Is it not possible, however, that the students' support of their instructors might hasten this settlement? And is it not possible that the profession might progress further — in every way — if more of its members and future members were willing to take a stand on an issue, instead of remaining *neutral?*

— V.A.L.

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Brighter lives for the old

It isn't too many years ago that geriatric care was carried out in "asylums" where patients were treated as incurable and hopeless. Many of these institutions were called Hospitals for Incurables.

Today, old people are no longer forgotten and neglected in old folks' homes. The attitude of the general public has changed and so has that of nurses. No longer are old people considered to be a chore, their care uninteresting and boring. Thanks to our enterprising and thoughtful nursing leaders, geriatric treatment has become known as "extended care"; here, good nursing programs work wonders for our aged ones who otherwise might have become a real burden.

This improved attitude to the old has led to the rehabilitation of paraplegics, many leading useful and busy lives from their wheelchairs. Cars are designed especially for them, and ramps are built for their convenience in hospitals or in their own homes. Physiotherapy and hydrotherapy is put into practice in swimming pools especially designed for easy entrance.

This type of work takes dedication on the part of the nurses involved. It can become tedious and very uninteresting unless the nurse takes a sincere interest in each patient as an individual with individual needs. The care of these people can prove rewarding when even a little progress is made by a seemingly helpless person after many exercises and attempts, perhaps over a long period of time.

In this field, "room number so and so" or "case number such and such" must be put aside and nurses must try to treat the patient as an individual personality with specific needs entirely his own. – Isobel Simpson, Prince Rupert, B.C.

The unsigned letter

The letter in the November 1968 issue entitled "A paid president?", signed "B.C. Nurse", annoyed me. In their vis-à-vis in the August 1968 issue, Mary Richmond and Monica Angus had the courage to present their opposing points of view on the issue of a paid president for our consideration. Surely we must have the courage to identify ourselves with issues we feel strongly about, if we are going to make progress in our professional association.

The unsigned letter, the mumbing in the back row at chapter or provincial Registered Nurses' Association meetings, the beefing at coffee break, may meet the needs of the individual but they certainly do not meet the needs of the group. I realize that the explanation for these kinds of activities is embedded in our tradition, but Mary Richmond and Monica Angus have made a breakthrough. Let's not slip back. – Patricia M. Wadsworth, Vancouver.

Books needed overseas

I am writing to you with regard to a problem faced by the Canadian Council for International Co-operation, in its program of sending educational books to schools, libraries and training centers in developing countries.

Several months ago, we received an urgent appeal from the Nirmala Hospital in Calicut (Kerala), India, for books on nursing science and practice and nursing journals for its training program. As our book centers have not received such books or journals for some time, we have been unable to meet this request.

We would appreciate any donations of such material, which can be sent to: the Overseas Book Centre, 207 Queen's Quay West, Toronto 1, Ont.; the Overseas Book Center, 4130 Verdun Ave., Montreal 19, Que.; or the Canadian Council for International Co-operation, 75 Sparks St., Ottawa 4, Canada. Anyone in another part of the country wishing to help could write to Ottawa for instructions on where to send the books.

We will undertake the cost of sending the books to the Nirmala hospital. If we receive more books than this hospital can use, we will have them sent to similar deserving institutions. – W.A. Teager, Ottawa.

Ostomy rehab — a necessity

In May 1962, after having had ulcerative colitis for five years, I underwent surgery that left me with a transverse colostomy. On my surgeon's instructions, a nurse attempted to teach me to irrigate; we thought we were following the instructions on the box, but did everything wrong. How easy it would have been to become discouraged; instead, as I recuperated, I became determined to become a self-taught enterostomal therapist dedicated to the idea that patients undergoing this surgery should have the support and guidance of a fellow 'ostomist.

My qualifications include an RN degree, extensive reading throughout my five-year illness, and the best teacher of all – living, coping, accepting. I was determined to convince the hospitals and doctors concerned that I was capable of offering a new service, not duplicating anything being done for 'ostomy patients.

I approached four surgeons in Victoria. They seemed interested in using the service I offered: a complete counseling service for 'ostomy patients and their families, preoperative care, postoperative care, fitting of appliances, and teaching of irrigation – in short, anything needed to accustom a patient to life with an 'ostomy.

It is four years since I was called to see my first patient – a frightened young woman facing an ileostomy after years of ulcerative colitis. I have just finished teaching irrigation procedure to my 67th patient – an elderly man fully accepting a colostomy. I have a good working relationship with most Victoria surgeons and full acceptance in the hospitals and with the local surgical supply house. My satisfaction comes from seeing frightened, depressed patients become cheerful, accepting people.

As I enter my fifth year of 'ostomy rehabilitation, I hope to expand the services I can offer to include more lecturing and teaching to hospital staff as well as the individual instruction of patients. There is a real need for stomal therapists and visiting members from 'ostomy clubs. Happy, accepting patients are a living testimonial to the necessity to continue this work. – Aileen E. Barer, R.N., Stomal Therapist, Victoria, B.C.

Uniforms create invisible barriers

I was interested in the letter entitled "Caps and uniforms – proud insignia" in the December 1968 issue. Perhaps the main reason that nursing is giving up its uniform and cap is that nurse-patient relationships are improved when nurses wear civies. This has been proven on psychiatric wards in the United States and Canada and it is being proven on general wards in various areas; Winnipeg's Victoria General Hospital is one example. As for "proud insignia," I believe that the school pin outranks the school cap!

Some nurses do look "handsome" and "imposing" in their white uniforms. However, there is no reason why the nurse cannot carry herself with pride and dignity minus a cap and in a dress of another color; she need not look "ordinary" or "dowdy" in civies.

Many nurses hide behind their uni-

(Continued on page 6)

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letters

(Continued from page 4)

forms, believing that they are more authoritative when wearing them. So be it. But let's think of patients oriented over the years not to argue with or question that figure in white, but to do what she says. In some hospital wards the patient is relegated to the status of a child unable to think for himself at all.

Public health nurses who, in Winnipeg at least, wear civies, meet the patient in his environment on an equal footing and as a friend. In my experience with public health nurses, I saw nothing that detracted from their knowledge, ability, bearing, or acceptance by patients because they wore civies.

Take the hospital nurse out of uniform, put her in a washable dress, and an invisible barrier is removed. Authority remains but friendship develops.

Let us put and keep our patients first. Our image will not be tarnished by what we wear. – Bonnie Kerr, Reg.N., 1968 graduate, Victoria General Hospital, Winnipeg.

December issue

I congratulate the circulation manager and the editors on the very nice format of the December 1968 issue.

As a librarian, it is very satisfying to me to see *The Canadian Nurse* join the group of journals publishing their yearly index in the December issue. Journals that do not follow this procedure cause librarians more headaches than enough, because we must wait so long for the index before we can have the journal bound. Congratulations! –Pauline Cummer, Librarian, Misericordia Hospital School of Nursing, Bronx, New York.

Prices compare favorably

I wish to commend the wide and excellent coverage given in the January 1969 issue of *The Canadian Nurse* to the Registered Nurses' Association of Ontario's Regional Conference on the Use of Audio-Visual Aids in Nursing held in Toronto from November 11-14, 1968.

However, in the interest of nurses who may attend future RNAO conferences, and possibly at the same hotel, may I correct the impression of an excessive price range as stated on page 24, and state that we have always experienced excellent service and quality, and that prices compare favorably with other hotels of a similar class across the province.

With the current cafeteria and dining room menus as my reference, I found that meals described in the article were being offered at approximately 40-50 percent less than prices quoted on page 24. Also, two city bus stops to the center of Toronto are within 75 yards of the main entrance, with service every 20 minutes. – Eleanor Trutwin, Secretary, Planning Committee, RNAO, Toronto.

Nursing scholarships

The Regina General Hospital School of Nursing Alumnae makes available a scholarship of five hundred dollars ($500) to active members of the Alumnae who are presently engaged in nursing. This scholarship may be used in any university school of nursing for post-graduate study. Completed applications must be received by June 1, 1969.

Application forms and further information may be obtained from: (Mrs.) Nora M. Kitchen, Chairman, Scholarship Committee, Suite 301, 2536 Parliament Avenue, Regina, Saskatchewan.

The Royal Canadian Army Medical Corps Fund announces an annual bursary of $300.00 for dependants of: (a) non-commissioned members of the RCAMC, Canadian Forces, who have been accepted for career status; (b) non-commissioned members or former members of the RCAMC, Canadian Forces, or CA(R), who have served a minimum of five years subsequent to 1950; (c) former RCAMC non-commissioned members of the CASF(Korea).

The bursary is an award to a dependent who has achieved satisfactory scholastic standing in the entrance, first, second or third year of a recognized Canadian university, teachers' college, school of nursing, or institute of technology course requiring a minimum of 2400 hours of instruction.

Further details may be obtained from the Secretary, RCAMC Bursary, Surgeon General Staff, Canadian Forces Headquarters, Ottawa 4, Ontario. – Lt. G.H. Rice, Secretary, RCAMC Bursary.

Alumnae wish to correspond

Members of the Alumnae Association School of Nursing, Jewish General Hospital, Montreal, are interested in corresponding with other nursing alumnae groups to exchange program ideas and projects.

Please write to: The Alumnae Association, Jewish General Hospital School of Nursing, 3755 Cote Ste-Catherine Road, Montreal. – Eileen Shalit, Montreal.

Journal needed

We are trying to find a copy of the February 1962 issue of *Nursing Outlook*. If any of *The Canadian Nurse* readers can supply this issue, please write to: Mrs. P.A. Whitaker, School Librarian, Royal Victoria Regional School of Nursing, 61 Wellington St.W., Barrie, Ontario.

news

Nurse Educators Go On Strike

Hamilton.—Members of the faculty of the Hamilton and District School of Nursing, with the exception of the director and assistant director, went on strike March 4 when they were unable to reach agreement with their employer.

The strike followed 11 months of unsuccessful negotiations with the employer. The 18 instructors, organized as the Nurses' Association Hamilton and District School of Nursing and certified as a collective bargaining unit by the Labour Relations Board on February 12, 1968, had met three times with management before asking the provincial minister of labor to appoint a conciliation officer last July. When the conciliation officer's attempts to effect a settlement were unsuccessful, a conciliation board was appointed in November. This board met with the two parties in January, but did not submit any recommendations to the minister of labor, apparently because the two parties were so far apart in their demands.

Areas of Disagreement

The chief areas of disagreement are: transportation expenses, educational leave, benefit plans, hours of work, work load, and salaries.

The Nurses' Association is asking for a flat rate of $15 per week to cover travel expenses and/or travel time involved, since teachers travel to the five outlying hospitals, where students receive their clinical experience, three or four days a week. Management has offered a cash allowance of three dollars a day "when no other transportation is available"; the Nurses' Association points out, however, that "available" often means taking a bus as early as 6:15 a.m. and arriving one and one-half to two hours before their starting time. No compensation for this inconvenience and loss of time is provided.

The Nurses' Association has also requested a maximum of 16 hours a week of teaching and a minimum of 16 hours a week for lecture preparation, with at least three hours required for other duties. The school board agreed to a 38 1/2 hour week, but made no concession for overtime work. Overwork is apparently a vital issue in the present impasse.

Salary demands by the teachers are related to the academic qualifications required by the school (Reg.N. with a university degree); the actual qualifications held by the present staff (all staff are registered nurses — some have a bachelor's degree, others have a master's degree); and current rates for teachers in secondary schools or colleges requiring equivalent education (for example, the 1968 salary range for instructors in Teachers' Colleges in the province was $11,218 to $13,279).



The Nurses' Association is asking for a minimum of $8,200 and a maximum of $12,400, achieved by 7 increments of $600 for teachers with a baccalaureate degree; and a minimum of $10,200 and a maximum of $14,400, with the same increments, for teachers with a master's degree. Management has offered $7,632 – $8,950 for teachers with a bachelor's degree, achieved by 5 annual increments of $264; and $8,112 – $9,432, with the same increments, for teachers with a master's degree.

Areas of Frustration

The 18 instructors list four areas of frustration in their negotiations:

- The employer's refusal to equate the instructors with other educators when deciding on salary and other benefits;
- The employer's refusal to bargain "in good faith," and the delaying tactics used since the instructors were certified as a collective bargaining unit.
- The impossibility of bargaining with "the ghost of the Ontario Hospital Services Commission," which has set wage scales for nurses in the province, but is not represented at the conciliation hearings.
- The suggestion by a management representative that the jobs of the nurse educators were more similar to instructors of welding apprentices than to secondary school teachers.

In a telephone interview with *The Canadian Nurse,* Jack Lowes, personnel director for the Hamilton and District School of Nursing, stated that salaries are the main stumbling block as far as management is concerned. "We just can't meet their salary demands," Mr. Lowes said. When asked to comment on the teachers' complaint that it is impossible to bargain with the ghost of OHSC, Mr. Lowes said "No comment." He did say, however, that the School cannot "get out of line

with what other nurse educators are being paid."

Mr. Lowes said that management refuses to equate the nurse educators' salaries with those paid to other educators, because "they [the nurse educators] are nurses, and are certified as nurses by the department of labor." He added that the nurse educators are really clinical instructors, and that they receive salaries comparable to those paid to other clinical instructors in the province.

Commenting on Mr. Lowes' statement, Anne Gribben, director of employment relations at the Registered Nurses' Association of Ontario, said: "We have two arguments against Mr. Lowes' reasoning. First, although these nurse educators are, indeed, certified as a Nurses' Association, they are *required* by management to have at least a bachelor's degree. Second, these nurse educators are *more* than 'clinical instructors.' They teach in the classroom, as well as in the clinical area, and are responsible for the counseling program for all students."

Mr. Lowes said that the School Board is doing its best to keep the school open. When asked whether there was a danger that the College of Nurses of Ontario might cease to approve the school because of the altered curriculum, Mr. Lowes sounded surprised, but admitted that the College did have this right.

He added that management was willing to submit the differences to an arbitrator appointed by the government. He agreed, however, that the teachers had the right to strike and did not have to submit to compulsory arbitration. According to Anne Gribben, the teachers believe they would be most unwise to submit their grievances to compulsory arbitration. "Past experience has shown that arbitrators do not always look at the facts," she said, "and have not awarded on the basis of what could have been obtained had the party involved had the right to strike."

The Registered Nurses' Association of Ontario, which greylisted the School when the instructors went on strike, expressed concern for the 156 students who are enrolled in the two-year course offered by the Hamilton and District School, but pointed out that the inflexibility of the employer leaves the teachers with no alternative other than to take "the only legal action open to them."

RNAO has worked closely with the instructors, helping them to organize for certification and to draw up proposals, and appearing with the Nurses' Association's representatives at the bargaining table.

CNA's 1968-70 Goals Approved

The goals of the Canadian Nurses' Association for the 1968-70 biennium were approved by the CNA Board of Directors at its meeting February 11-14. They will be published shortly as a separate document for members.

The goals call for CNA to:

1. Prepare and arrange for the 14th Quadrennial Congress of the International Council of Nurses, Montreal, June 22-28, 1969, and welcome the nurses of the world.

2. Support and promote the program of ICN and other international organizations concerned with world-wide health, education and welfare.

3. Continue to make representations on behalf of Canadian nurses to the federal government, its departments and commissions in the interests of nursing and related national and international health services.

4. Promote continuing improvement in communications and cooperation between CNA and related national and international health services.

5. Advocate support of the Canadian Nurses' Foundation.

6. Establish a national testing service to prepare tests that may be purchased and used by the provincial registering bodies for the licensing and/or registration of nurses.

7. Study national and provincial nurses' association relationships, functions, membership, fee structure, and legislation.

8. Continue to develop standards for nursing service and nursing care in order to provide systems for evaluation of quality of nursing service and nursing education programs.

9. Continue to work toward the provision of systems for improving standards of nursing service and nursing education programs.

10. Encourage the development of nursing diploma programs in educational institutions within the general system of education at the post-secondary level.

11. Promote continuing education programs, particularly those directed by educational institutions, for the two identified categories of nurse practitioners.

12. Reflect the beliefs and policy of CNA in a revised statement on the nurse's social and economic welfare.

13. Reassess national goals for salaries, social welfare and conditions of work for nurses graduating from the baccalaureate and diploma programs.

14. Provide consultation services to the 10 provincial nurses' associations as feasible.

15. Encourage research in relevant areas, especially in clinical nursing practice, to improve nursing care.

16. Promote continuing improvement in communications between CNA and its individual members and between the Association and the Canadian people.

17. Publish material on selected topics that will help to meet CNA's goals.

18. Initiate dialogue with allied health professions on the proliferation of categories of health workers with a view to formulating policies in this area.

Daily Registration Fee For ICN Congress Reduced

Ottawa.—The daily registration fee for the XIV Quadrennial Congress of the International Council of Nurses, to be held June 22-28 in Montreal, has been reduced from $15 per day to $10.

Daily registration will take place Monday June 23 to Friday June 27 only. Daily registrants will not receive the kit containing the official program, and will not be allowed to attend the special interest sessions or the opening and closing ceremonies.

Three Nurses Appointed To Federal Task Forces

Ottawa.—Three nurses are among the 40 members of seven task forces on health costs announced by Health and Welfare Minister John Munro in late February.

They are: Louise Miner, president-elect, Canadian Nurses' Association, appointed to the task force on public health services; Margaret McLean, CNA second vice-president, task force on salaries and wages; and Myrna Sherrard, Moncton City Hospital, N.B., task force on operational efficiency.

In addition, one task force — on methods of delivery of medical care — has asked the CNA to present its official current views on the future role of the nurse in delivery of medical care. Four representatives of the association came before the task force March 3 for this purpose.

The seven task forces will prepare reports for the federal-provincial committee on costs of health services. Members include federal and provincial representatives as well as professional persons from related health fields.

Membership in the task forces was determined by the secretariat established for the national study, following consultation with task force chairmen, federal and provincial health authorities, and related health associations. None of the 10 chairmen and co-chairmen are nurses.

The extensive study into health costs will cover three major areas: hospital services, medical care, and public health services. Four task forces will look at factors involved in the provision of hospital care and services; two groups will examine areas pertinent to the provision of medical care; the seventh will investigate costs of public health services.

(Continued on page 12)



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news

(Continued from page 8)

CNA Asks Government For A Million Dollars More

Ottawa.—The Canadian Nurses' Association, in a brief presented this month to the Commission on Relations between Universities and Governments, recommends that the federal government appropriate a minimum of one million dollars per year for the preparation of nurses at the baccalaureate and master's levels, and $100,000 for doctoral study. This amount would be in addition to the present Professional Training Grant Bursaries now being offered. The Bursaries, CNA recommends, should be used only for study at the university level.

The brief, prepared on behalf of CNA by Shirley R. Good, the Association's consultant in higher education, noted that in 1967-68 the federal government allotted $807,247.31 to nursing students through the Professional Training Grant Bursaries fund. This figure represents a decrease of more than $100,000 per annum in federal grants to nursing students since 1966-67, and a decrease of $152,452.53 compared to the bursaries given in 1965-66. The brief noted also that in 1967-68, only 8.5 percent of nurses studying for baccalaureate degrees and 23.2 percent of those enrolled in master's studies received financial assistance from the federal government. No figures were available for nurses studying at the doctoral level.

In the brief, Dr. Good pointed out that there is an "absolute famine" of university-prepared nurses in Canada. The CNA's national objective of one nurse with a bachelor's degree to three diploma nurses has not been reached; the 1968 ratio was 1:18. Only .5 percent of Canadian nurses hold a master's degree; the CNA's objective is 14-15 percent.

The CNA submission to the Commission on Relations between Universities and Government also recommends that the federal government give an explicit and accurate account of monies appropriated to nursing. This would include a breakdown of the provinces, institutions, and numbers of people involved.



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Professional Institute Is Bargaining Agent For Federal Nurses

Ottawa.—The Professional Institute of the Public Service of Canada became the certified bargaining agent March 3 for 2,200 nurses employed by the federal government.

The bargaining unit contains virtually all federally employed nurses at the general duty, head nurse, and supervisory levels. Anne Gribben, employment relations director, Registered Nurses' Association of Ontario, said this step "exemplifies just what we're trying to do: create unity in the profession. We are nurses first – our job classifications are secondary.

"It's an idealistic type of composition," she continued. It's broad and gives all employees the right to bargain."

Ethel Gordon, consultant for health service groups with the PIPS, said the Institute is at present working on contract demands for nurses for the two-year period starting July 1, 1967, so the work is urgently needed.

The nursing group is in the scientific and professional category of public servants. The defence, health and welfare, and veterans' affairs departments are the prime employers of the nurses.

Professional Liability Insurance Available to ANPQ Members

Montreal.—An insurance plan to protect professional nurses in the case of costly malpractice suits is now available to members of the Association of Nurses

of the Province of Quebec, after months of investigation and study by provincial office. This information appeared in the January issue of *News and Notes,* a publication of the ANPQ.

The ANPQ Committee of Management recently approved the plan for professional liability insurance proposed by the Reliance Insurance Company of Canada. Although the ANPQ has approved the plan, it does not administer it. Nurses wishing to avail themselves of this protection have been advised to apply directly to the insurance company.

The ANPQ study of professional liability insurance was conducted following many requests for information by ANPQ members, who were anxious to know if such insurance plans were available and how they could be obtained.

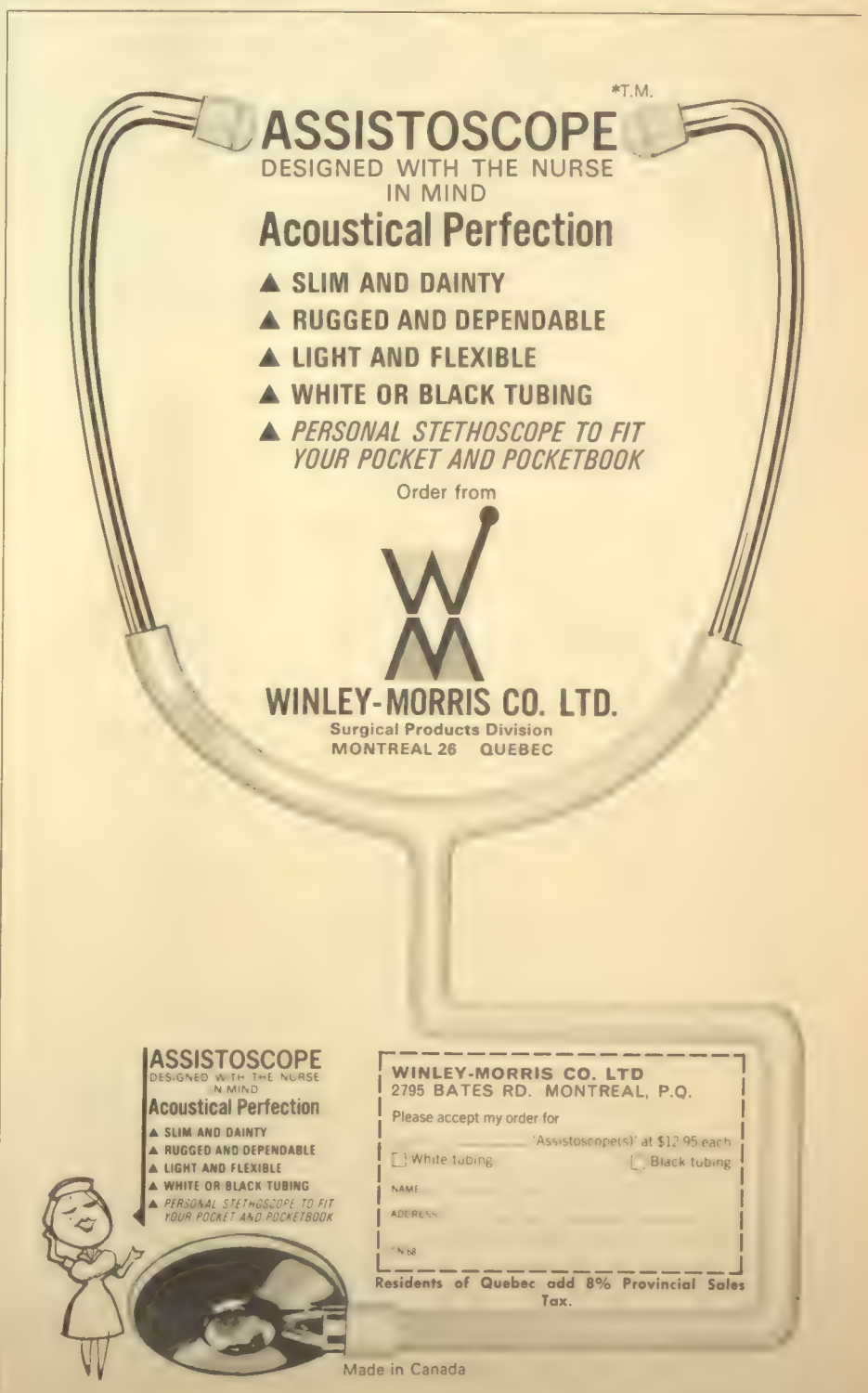
AARN Presents Brief To Cabinet

Edmonton.—The Alberta Association of Registered Nurses presented its annual brief outlining the Association's activities and concerns to Alberta Premier Harry E. Strom and members of his cabinet January 10.

The brief highlighted AARN's progress and development during 1968 in the areas of nursing service, nursing education, and social and economic welfare. Items were included on membership statistics, developments in nursing education, and research programs in which AARN is involved.

The following nursing service items were included:

- The Alberta Medical Association, the Alberta Hospital Association, and AARN have endorsed "Guidelines for Medical-Nursing Responsibilities" which are now being used by medical, nursing, and administrative personnel in the development of local policy.
- AARN's nursing service committee is working on guidelines for administrative personnel in determining hospital staff assignments. Registered nurses are performing many duties which cannot be classed as nursing functions, and AARN recommended these non-nursing duties be reallocated as far as possible to the department involved. Where the nurse must carry some of these duties, a more realistic computation of nursing care hours should be carried out.
- AARN recommended a hospital indices program, including: study of each hospital as to the influence of variables in the staffing pattern; consideration of the various services offered by the hospital and its geographic location; examination of the number of graduate nurse personnel and their position in each institution; and study of the use of registered nurses in relation to the activities and responsibilities they assume.
- The brief suggested that "Good Samaritan" legislation, which would protect people from liability for any civil damages for acts or omissions at the scene of an accident, would be in the public interest. Premier Strom requested the AARN to submit an outline for proposed legislation on this subject to Manitoba's Attorney General and Health Minister.
- AARN has agreed to set down for the Hospital Services Division of the Department of Health a definition of nursing in terms of goals, in a project "to define basic nursing care at the acute, sub-acute, chronic and rehabilitative levels."
- AARN endorsed the recommendations of Manitoba's Special Legislative and Lay Committee inquiring into Preventive Health Services that all the necessary health services already in existence be invited to participate in an organized home care scheme.
- AARN feels the role of the certified nursing aide requires close examination to ensure that this role reflects present



hospital requirements.

The brief was presented by AARN President Geneva Purcell, accompanied by members of AARN's provincial council and standing committee chairmen.

RNAO Plans Programs For ICN Visitors

Toronto.—The Registered Nurses' Association of Ontario has invited nurses from other countries who are attending the International Council of Nurses' Congress in Montreal this June to participate in the many visits and study programs being planned by RNAO.

RNAO sent a letter, through CNA, to each ICN member country, giving information about the programs that will be available during either of the two weeks preceding or the week following the Congress. These include specialized study programs, visits to hospitals and health agencies; and a symposium on nursing service and nursing education to be held at RNAO headquarters each of the three Mondays preceding the observation visits.

F. Lillian Campion, RNAO's international secretary on the staff of the Professional Development Department, is in charge of the planning.

Provincial Associations Help With ICN Congress

Ottawa.—Three more provincial nurses' associations have presented cheques to the Canadian Nurses' Association to aid in the costs of the XIV Quadrennial Congress of the International Council of Nurses, June 22 to 28 in Montreal.

The Saskatchewan Registered Nurses' Association has given CNA $3,000; the Registered Nurses' Association of Nova Scotia has donated $2,000; and the Manitoba Association of Registered Nurses has presented $800.

In addition, six provinces are sending their public relations officers to assist at the Congress. They are: Claire Marcus, from the Registered Nurses' Association of British Columbia; Don LaBelle, Alberta Association of Registered Nurses; Pearl Morcombe, MARN; Isabel LeBourdais, Registered Nurses Association of Ontario; Nancy Rideout, New Brunswick Association of Registered Nurses; and Gertrude Shane, Registered Nurses Association of Nova Scotia.

In the March issue of *The Canadian Nurse* it was erroneously stated that Norma Fieldhouse was RNABC's public relations officer. She is public relations committee chairman.

The Presidents Go For A Ride



Dr. H.D. Dalgleish, president of the Canadian Medical Association, pulls a toboggan-full of CMA-CHA-CNA Conference delegates during time off at the Second Canadian Conference on Hospital-Medical Staff Relations in Quebec City. Left to right: Sister Mary Felicitas, president of the Canadian Nurses' Association; Alan Hay, president of the Canadian Hospital Association; Juliette Pilon, director of nursing, Rosemount Hospital, Montreal: Ola Robitaille, director of nursing at Jean-Talon Hospital, Montreal; and Helen K. Mussallem, executive director of the Canadian Nurses' Association.

CNA, CMA, CHA Discuss Hospital-Medical Staff Relations

Quebec City.—Doctors, nurses, hospital administrators and trustees were subject to a sound drubbing at the first day of the Second Canadian Conference on Hospital-Medical Staff Relations, February 17 to 19. Dr. E.W. Barootes, chief urologist at Regina General Hospital and keynote speaker, accused nurses of losing their nursing sense and replacing it with a "demoniacal devotion to administrative bureaucracy," and administrators and other hospital groups of trying to run illnesses on a nine to five daily basis. Doctors were attacked for keeping patients in hospital only because it is easier to care for them there than at home.

The conference was sponsored jointly by the Canadian Hospital Association, the Canadian Medical Association, and the Canadian Nurses' Association to improve communication among hospital personnel. Alan Hay, president of the CHA, presided over the conference.

Dr. Barootes' address was supplemented on the final day of the conference by an address by Dr. A.B. Powell, director of medical services for the Ontario Workmen's Compensation Board, entitled "Effective Medical Services."

The participants of the conference were divided into four study groups of approximately 100. Before beginning their discussions, the groups were addressed by Russell J. Porter, principal associate of Willson Associates, Limited on "Conference Goals."

At the conclusion of the conference, the four group leaders presented reports on the progress of their groups. The first report, delivered by W.C. Gardner, listed several recommendations, including: regionalization of conference workshops with regard to size and areas of problems; circulation of agenda prior to conferences and the discussion of questions and topics of each group present.

Group II, represented by Dr. F.M. Christie, recommended that regional conferences run by the three sponsoring associations be established, and that the national conference be less frequent.

Group III made one recommendation, presented by Dr. K.H. MacKay: that the Canadian Hospital Association, the Canadian Medical Association, and the Canadan Nurses' Association approach the proper authorities so that research funds will be increased to attract medical and nursing teachers of the highest calibre.

The fourth group, which was conducted in French, made several recommendations, including the following: that Dr. Barootes' speech be translated into French and distributed in either language

to participants; that the participants be given a choice of groups; and that French and English groups be intermingled, with simultaneous translation.

The third conference will be held in Banff, Alberta, next year.

CNF Board Meets And Appoints New Officers

Ottawa.—The Canadian Nurses' Foundation's board of directors elected Hester J. Kernen, associate professor in public health nursing, University of Saskatchewan, as president, and Albert Wedgery, associate director, College of Nurses of Ontario, as vice-president at its meeting at National Office March 10.

The CNF board also appointed members to the nominating and selections committees of the Foundation. Names of members will be released on their acceptance of the appointments.

Concern about the low membership in CNF was expressed by the board members. They agreed that a letter should be sent to former CNF scholars, asking for their support in promoting the Foundation. Because of the present financial situation of CNF, the board agreed that priority must continue to be given to scholarships, rather than to research, to help prepare nurses for positions of responsibility.

To date, approximately $35,000 is available for 1969 fellowship awards, as compared to $57,000 awarded in 1968. Membership in CNF can be obtained by sending a cheque for two dollars to: CNF, 50 The Driveway, Ottawa 4. Fees and donations are tax deductible.

Two Students Selected To Attend ICN Congress

Sudbury.—Two students at Laurentian University School of Nursing will be given financial assistance to attend the XIV Quadrennial Congress of the International Council of Nurses to be held June 22 to 28 in Montreal.

Louise Picard and Rosemary Boyle were selected to receive the award. It is given in memory of Wilda Sims, a former faculty member at Laurentian University, who died in December 1968. During her 25 years as nurse educator, over 600 students graduated under her administration.

NBARN Sponsors Inservice Education Workshop

Memramcook, N.B.—"Better Patient Care with Inservice Education" was the theme of a two-day workshop held here in March. Sponsored by the nursing service committee of the New Brunswick Association of Registered Nurses, the workshop was expected to attract nurse representatives from some 30 hospitals and agencies in the province.

Workshop leader was Mona Callin, lecturer in nursing, McGill University, Montreal. Miss Callin's background is in the area of adult education and inservice coordination.

Purpose of the workshop was to assist in improving patient care in New Brunswick by improving inservice education programming for nursing service staff. Topics included: inservice education philosophy and objectives; obstacles to effective inservice programming; adult versus youth learning; philosophy of adult education; types of leadership; effective group efforts; planning an in-service project.

NLN Conference To Consider Health in Community

New York.—"Partners for Health — Nursing and the Community" is the

(Continued on page 18)

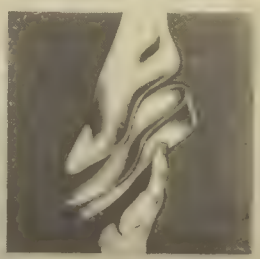
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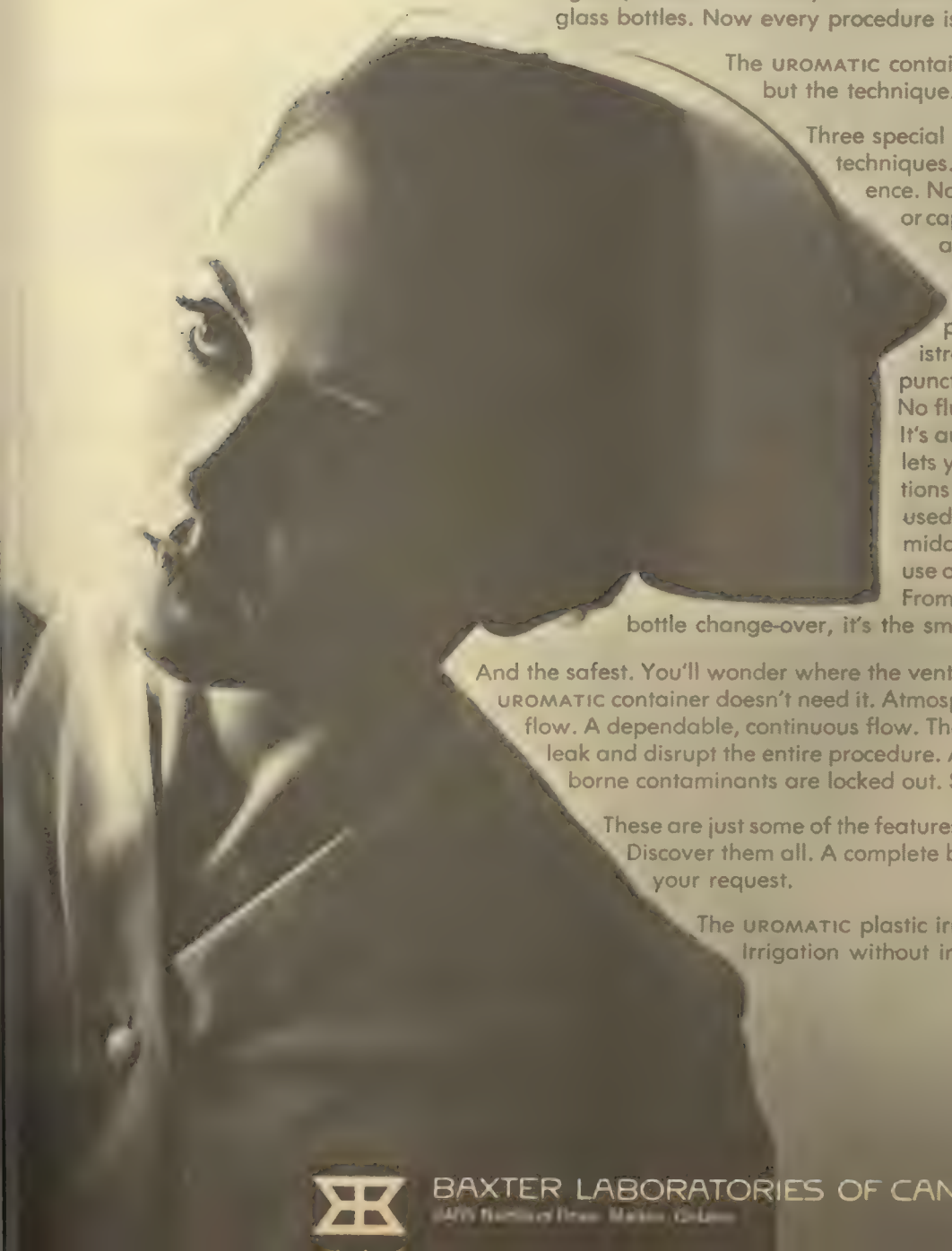
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news

(Continued from page 15)

theme of the National League for Nursing Convention to be held in Detroit, May 19-23. Keynote speaker will be Dr. Philip M. Hauser, director of the Population Research Center and professor of sociology at the University of Chicago, who will speak on "Urban USA – A Chaotic Society? "

The convention participants will consider the theme in large general sessions, in "think-ins and talk-backs," at luncheon meetings, and at seminars throughout the convention. Other speakers include L. Ann Conley, president of NLN; Dwight L. Wilbur, president of the American Medical Association; Margaret B. Dolan, head of the department of public health nursing at the University of North Carolina; and Richard Magraw, deputy assistant secretary for health manpower, US Department of Health, Education, and Welfare.

Panel discussions will consider "Mobilizing for Community Health," and will take a new look at the people who make up today's health team. During the week, other programs designed to bring information to members on new methods of health care are scheduled. All NLN councils of agency members will meet during convention week, and the annual convention of the National Student Nurses' Association will take place in the week preceding the conference in Chicago.

ICN Nominations Announced

Geneva, Switzerland.—Nominees for elected positions in the International Council of Nurses for 1969-1973 were announced early in 1969 in Geneva. Elections will take place during ICN's 14th quadrennial congress in Montreal, June 22-28. Votes may be cast by the Council of National Representatives, composed of the presidents of the 63 national nurses' associations in membership with ICN.

To be elected for the four-year term are a president, three vice-presidents, board of directors, and members of the standing committees on membership and professional services. Each nominee has been certified as a nurse who is an active member in a member association.

Two nurses have been nominated as ICN president: Margrethe Kruse, chairman of ICN's Professional Services Committee 1965-69 and executive secretary of the Danish Nurses' Organization; and Dame Muriel Powell, DBE, member of the ICN Board of Directors 1965-1969 and matron at St. George's Hospital, London, U.K.

There are three nominees for the three posts of first, second and third vice-president: Dorothy A. Cornelius, president, American Nurses' Association; Ruth Elster, ICN second vice-president, 1965-1969, and president, German Nurses' Federation; and Alice Girard, ICN president, 1965-1969, of Canada.

Nominees for the Board of Directors are: Nicole F. Exchaquet, Switzerland; Barbara Fawkes, U.K.; Nelly Goffard, Belgium; Jadwiga Izycka, Poland; Docia A.N. Kisseih, Ghana; Jane Martin, France; Joyce C. Rodmell, Australia; Julita V. Sotejo, Philippines; Gerd Zetterstrom Lagervall, Sweden.

Sixteen nurses have been nominated for membership on the ICN Membership Committee, including Lyle Creelman, a member of the Canadian Nurses' Association and formerly chief nurse, World Health Organization. Among the 23 nominees for the Professional Services Committee is Laura W. Barr, executive director of the Registered Nurses' Association of Ontario and member of this committee in 1965-1969.

Hospital Personnel Relations Bureau Set Up

Toronto.—Any hospital in Ontario can now turn to the Hospital Personnel Relations Bureau for help in dealing with labor problems.

By the end of January, the bureau's first month of full-time operation, 56 Ontario hospitals had joined this independent organization. Ontario is the fifth province to form such a "self-help" central bargaining body.

The bureau concept developed through several meetings of the Ontario Hospital Association. At a meeting of OHA representatives in March 1968, a basic bargaining problem was seen in negotiations carried out by management representatives of an individual institution who were sometimes less knowledgeable than their union counterparts. OHA representatives believed that such a situation tended to expose hospitals to: one institution "playing off" another. and similar and separate negotiations occurring in one hospital industry in a given time, thus making invidivual negotiations very time-consuming.

The main function of the bureau is to coordinate the labor relations efforts of its member hospitals for their mutual advantage. The bureau emphasizes, however, that it has no intention of interfering with the autonomy of any hospital. and will act only when authorized by a hospital.

D. Alan Page, manager of the bureau. says that the bureau's services are designed to help hospitals with or without unions.

The objectives of the bureau include:

- Development of uniform contracts in regions of the province.

- Acting as a source of information on hospital labor matters.
- Maintenance of fair salary scales for all hospital employee classes.
- Interpretation of contracts and assistance in gaining settlement of disputes.
- Investigation of salaries for nurses and other paramedical people.
- Establishing relations with other similar bodies in Canada.

Quebec Male Nurses Seek Legal Recognition

Montreal.—"Male nurses in the province of Quebec are not losing hope even though their grievances were not discussed at the last session of the Quebec parliament," said Jean Robitaille, president of the Graduate Male Nurses of Quebec in an interview with *L'infirmière canadienne.*

Male nurses at present do not have any legal status in Quebec and cannot legally be hired to practice as nurses in the province. There are 525 male nurses in Quebec, many of whom hold a bachelor's or even a master's degree in nursing, despite the fact that they do not possess legal authorization to practice in Quebec. The Association of Nurses of the Province of Quebec fully supports the principle that male nurses should be authorized to practice; however, the Association cannot grant them registration until the present nursing act is amended by the Quebec parliament.

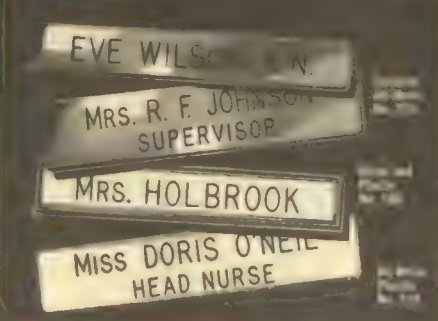
"In 1966 the legal right of male nurses to practice in Quebec was included in an amendment to the Quebec Nurses' Act and scheduled to be discussed in the Quebec parliament," continued Mr. Robitaille. "Since that time, there has been a provincial election and a change in the government. The late Premier Daniel Johnson promised to consider our problem, and at the last session, the discussion on Bill 85 – which concerns the rights of minorities in Quebec – took priority over discussion of our proposed amendments to the Nurses' Act. We sincerely hope that the amendment will be discussed and approved during the parliamentary session that began February 25."

Maurice Jacques, the lawyer representing the Quebec male nurses, plans to meet in the near future with Jean-Paul Cloutier, Quebec's minister of health, to impress upon him the urgency of the problem.

Red Cross Bursary Offered to Ontario Nurses

Toronto.—A $1,000 bursary is being offered to graduate nurses registered in

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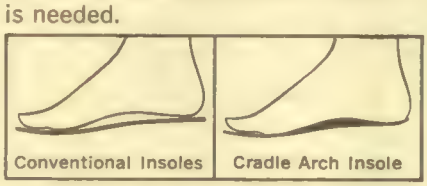
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Ontario by the Volunteer Nursing Committee of the Canadian Red Cross Society. The award is to enable the recipient to take further studies in nursing at the degree level.

The successful candidate will be selected on the basis of training, nursing experience, and leadership qualities; consideration is also given to the applicant's anticipated contribution to nursing in Ontario.

Butterfly With a Broken Wing



Montreal.—The Quebec Society for Crippled Children has adopted a new emblem — a butterfly with a broken wing. The symbol will appear on the Society's stationary, its cars, and on all materials used in this year's fund-raising campaigns.

According to a brochure sent out by the Society, last year $103,914 was spent on orthopedic appliances, wheelchairs, special shoes, braces, and other equipment necessary for young handicapped children. The society also provided specialized medical and nursing care for handicapped youngsters and provided camps and treatment centers for nearly 500 physically handicapped children.

Naegele Fund Trustees Report On Progress Of Children

Vancouver. — Trustees of the Kaspar Naegele Educational Trust Fund have reported on the progress of Dr. Naegele's three children. Dr. Naegele, formerly Dean of Arts at the University of British Columbia, was preparing a study of nursing education in Canada at the time of his death in 1965.

The Educational Trust Fund was set up shortly after Dr. Naegele's death to provide for the education of his three children. Helen K. Mussallem, executive director of CNA, is one of the trustees. CNA donated the remaining money set aside for Dr. Neagele's report, some

$1,200, to the Fund. Several nurses donated individually.

The report says that Janet and Timothy, the younger children, have rejoined their mother in Vancouver after a stay with their uncle in Northampton, Massachusetts. They are now in school in Vancouver. Barbara, the eldest child, is in her final year of science at UBC.

Health & Welfare Department Marks 50th Anniversary

Ottawa.—This year the Department of National Health and Welfare marks the achievement of 50 years of service to the people of Canada.

Specials events are taking place during April to mark this anniversary, plus publication of a commemorative issue of the Department's magazine *Canada's Health and Welfare.*

The Department was first formed as the Department of Health in 1919. In 1929 it was renamed the Department of Pensions and National Health. Its broad purpose has been to provide all Canadians with the highest standards of personal and collective health, and to provide assistance to the many who cannot or only partially can assist themselves in the business of daily living.

The activities of the Department during the first half of these 50 years were of a curative nature, devoted to attempts to solve problems that had grown beyond the capabilities of provincial and private organizations.

Considering the present-day concern with water pollution, it comes as a surprise to realize that as early as 1923 a division for its control was established within the Department.

The second 25 years, however, have been marked by the assumption of a preventive task. Much more effort has been devoted to allaying the cause of illness, and much new legislation has been geared to provide security and health benefits for the young, the old and the infirm. This new direction was demonstrated in 1944 when the Department was given its present title.

This reorganization drew together activities that had been the responsibilities of other departments. Divisions directing their efforts to new areas of national health and welfare were started. Things have happened thick and fast during the last decade, most recently the Canada Pension Plan of 1965, the subsequent Guaranteed Income Supplement, and the Canada Assistance Plan. These many social legislations are either a total federal responsibility or operated jointly with the provinces.

Charge Made For Study Tours To UK

London, England.—A charge of 10 to 15 pounds will now be made for study tours in the United Kingdom for overseas nurses arranged by the Royal College of Nursing and National Council of Nurses of the United Kingdom. A charge of one pound will also be made for work undertaken by RCN's international department on behalf of foreign nurses wishing to work in the UK.

This new ruling took effect April 1, 1969. The decision was taken to offset to some extent the heavy administrative expenses of the international department rather than to curtail the facilities offered by the department for nurses from abroad. There may be exceptional circumstances when this general ruling should be waived.

The charge for a study tour will vary depending on its length and complexity. A charge is also made for work undertaken by the international department for RCN members wishing to work or study overseas. □



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names



Eleanor Mitchell joined the staff of *The Canadian Nurse* as assistant editor in March 1969. A graduate of the Toronto General Hospital School of Nursing, Miss Mitchell received a postgraduate diploma in neurological nursing from the Montreal Neurological Institute, and a Bachelor of Nursing Degree from McGill University.

The new assistant editor has had experience on the neurosurgical unit at Toronto General Hospital and for several years was assistant director of nursing education in charge of a nursing assistants' program at Peel Memorial Hospital in Brampton, Ontario. Before coming to Ottawa, she taught students at the Credit Valley School of Nursing in Mississauga, Ontario.

Edna L. Moore, a pioneer in public health nursing, died in Toronto February 25 at the age of 77.

Dr. Moore's active, 44-year nursing career began in 1913 when she graduated from the Toronto General Hospital School of Nursing. After working two years at TGH, Dr. Moore spent four years overseas as a Nursing Sister with the Canadian Army Medical Corps. She returned to Canada to work as a social service nurse with the Department of Soldiers Civil Re-establishment.

Dr. Moore first worked for the Ontario Department of Health as a social service nurse with the Division of Preventable Diseases from 1920-24. She then went to New York State, first as a supervisor of social hygiene and two years later as the assistant director of the national organization for public health nursing. While in the United States, Dr. Moore studied maternal and child hygiene, venereal disease control, social work, and tuberculosis control. From 1927 to 1929 she was a field worker with the Canadian Tuberculosis Association in Ottawa.

In 1931 Dr. Moore joined the Ontario Department of Health as chief public health nurse. She became the first director of the Public Health Nursing Division when it was formed in 1944, the position she held until her retirement in 1957.

Dr. Moore's leadership extended to many professional associations. She served on the editorial board of the *Canadian Journal of Public Health;* was a vice president of the Canadian Public Health Association from 1956-57; was first vice president and then president of the Ontario Public Health Association from 1953-54; and was elected first vice president of the Registered Nurses' Association of Ontario in 1946. After retirement, she conducted a study of nursing registries for the RNAO. From 1940 to 1947, Dr. Moore served as chairman of the Public Health Committee of the International Council of Nurses. She was also active in the Canadian Red Cross, Ontario Society for Crippled Children, Canadian Cancer Society, and the Nursing Council of the University of Toronto School of Nursing.

In recognition of her leadership, Dr. Moore received the Associate Royal Red Cross in 1919, the George V Jubilee medal, and was made a Fellow of the American Public Health Association. In 1956 the University of Western Ontario honored Dr. Moore for her public health service with an honorary Doctor of Laws degree.In 1968 at Laurentian University in Sudbury, Ontario, she presented the first Dr. Edna L. Moore scholarship – awarded, most fittingly, for excellence in the practice of nursing.



Mother Virginie Allaire, founder of L'Institut Marguerite d'Youville, the first school of higher education for French-speaking nurses, died in January at the motherhouse of the Grey Nuns of Montreal.

Born in Grafton, Massachusetts, Mother Allaire joined the Order of the Grey Nuns of Montreal in 1904. Later, she returned to the U.S. to complete her nursing education at Morristown Hospital in New Jersey. Her professional career included: director of nurses at St. Peter's Hospital in New Brunswick, New Jersey; provincial superior at St. Boniface; business manager of the Grey Nuns of Montreal community; and director of L'Institut Marguerite d'Youville, which she founded in 1934.

During her lifetime, Mother Allaire received recognition from many organizations for her outstanding contributions to nursing and to various professional associations. In 1936, she was awarded an honorary doctoral degree by the University of Montreal; in 1940, she received the silver medal of the Canadian and U.S. hospital associations for distinguished service; she was made a Fellow of the American College of Hospital Administrators; and in 1960 she was made an honorary member of the Canadian Nurses' Association.



Elaine Audrey McEwan (B.N., U. New Brunswick; M.Sc.N., Cert. Nurse-Midwifery, Yale U., Mass.) has been appointed lecturer at the school of nursing, University of New Brunswick. Miss McEwan assumed her position in July 1968.



Annetta L. Landon (Reg.N., Toronto General; Dipl. Teach. & Superv., McGill U.) recently retired from her position as director of nursing services at Ottawa Civic Hospital after 22 years of service at the Civic. Before coming to Ottawa, Miss Landon worked at Toronto General Hospital for 16 years as operating room nurse, supervisor of the radiology department, and operating room supervisor.

Throughout her nursing career, Miss Landon has been active in the Registered Nurses' Association of Ontario.

Sixteen new instructors joined the staff of the school of diploma nursing at the Saskatchewan Institute of Applied Arts and Sciences, Saskatoon, in September 1968.

Charlotte A. Annable (B.S.N., U. Saskatchewan) formerly worked as a general duty nurse at The Winnipeg General Hospital. **Rose-Aline Begalke** (R.N., Saskatoon City H., Dipl. Teach. & Superv. U. Saskatchewan) taught pediatrics for one year at Medicine Hat General Hospital, Alberta, and orthopedics and urology for two years at St. Paul's Hospital in Saskatoon.

S. Maureen Campbell (R.N., Misericordia General, Winnipeg; Dipl. P.H.N. McGill U.) formerly was employed by the Saskatchewan government as a public health nurse in Unity, Saskatchewan and

names

Meadow Lake, Saskatchewan. Miss Campbell has also worked as a general duty nurse in Germany, Maryland, California, and Saskatchewan.

K. Anne Harris (Reg.N., Ontario H., Brockville; Dipl. Nurs. Educ., U. Western Ont.) comes to Saskatchewan from Brockville where she was an instructor at the Ontario Hospital. **Joyce M. Klingman** (R.N., Yorkton Union H., Sask.; Dipl. Teach. & Superv., U. Alberta) previously spent a year at Yorkton Union Hospital as a general duty nurse.

Phyllis E. McElroy (R.P.N., Saskatchewan H., Weyburn; Dipl. Teach. & Superv., U. Saskatchewan) has had 10 years experience as an instructor for the Saskatchewan department of health at Yorkton Psychiatric Centre and in Weyburn.

Donna C. Miller (B.S.N., U. Saskatchewan) previously taught for a year at the school of nursing, University of Saskatchewan. **Patricia A. Moyer** (R.N., Regina Grey Nuns' H.; B.Sc.N., U. Windsor) formerly worked as a general duty nurse at Regina Grey Nuns' Hospital.

Stella Pankratz (R.N., U. Saskatchewan; B.Sc.N., U. Alberta) has worked as a staff nurse at St. Margaret's Hospital, Biggar, Saskatchewan, and at Rosthern Union Hospital, Saskatchewan. From 1967 until her present appointment, she has been head nurse at Glenrose Provincial Hospital in Edmonton. **Sheila E. Perry** (R.N., The Winnipeg General Dipl. Teach., U. Saskatchewan) has worked as a general duty nurse at The Winnipeg General Hospital, St. Joseph's General Hospital in Estevan, Saskatchewan, and University Hospital, Saskatoon.

Blondina F. Peters (R.N., B.Sc.N., U. Saskatchewan) previously worked at Kingston General Hospital, Ontario and University Hospital, Saskatoon as a staff nurse. **Olivia M. Sane** (R.N., Regina Grey Nuns' H.; Dipl. Teach. & Superv., B.Sc.N., U. Saskatchewan) formerly worked as an instructor in Moose Jaw, Regina, Ottawa, and Hamilton.

Judith M. Scanlan (R.N., Regina General; B.N., U. Manitoba) comes to Saskatoon from Winnipeg where she taught at The Children's Hospital of Winnipeg. She had previously worked as a general duty nurse in North Vancouver and Winnipeg. **Catherine M. Seymour** (B.Sc.N., U. Saskatchewan) formerly worked for a year as an instructor at Holy Cross Hospital in Calgary.

Nevin N. Surring (R.P.N., Saskatchewan H., Weyburn; Dipl. Teach. & Superv., U. Saskatchewan) has experience as an instructor at Yorkton Psychiatric Centre, Saskatchewan and Saskatchewan Hospital in Weyburn. **Mary A. Symon** (R.N., Regina Grey Nuns' H.; Dipl. P.H., U. Manitoba) previously worked in Saskatoon's St. Paul's Hospital as a staff nurse, head nurse, and instructor, and in Calgary's Holy Cross Hospital as a health nurse.



Joyce O. Shack (Reg.N., Victoria H., London, Ont.; Dipl. Nurs. Educ., B.Sc.N., U. Western Ont.) has been named director of nursing service at Plummer Memorial Public Hospital in Sault Ste. Marie, Ontario. Miss Shack leaves her position as director of nursing service at St. Joseph's Hospital, Sarnia, Ontario. She has also held positions as a general duty nurse at Victoria Hospital, London, Ontario; head nurse at Sydenham District Hospital, Wallaceburg, Ontario; and instructor at Sarnia General Hospital, Ontario.



M. Colleen Stainton (R.N., The Vancouver General; B.Sc.N., U. British Columbia) has been named instructor in maternal and child care at Mount Royal Junior College, Calgary.

Miss Stainton previously was an instructor in medical-surgical nursing at Foothills Provincial General Hospital, Calgary. From 1963 to 1966, she was an instructor in obstetrical nursing at Holy Cross Hospital in Calgary.



Ethel M. Gordon (R.N., The Winnipeg General.; Dipl. P.H.N., U. Toronto) former chief nursing advisor in the Public Service Health Division of the Department of National Health and Welfare has retired after 21 years service. Miss Gordon has now taken a new position with the Professional Institute of the Public Service of Canada as nursing consultant.

Miss Gordon joined the former Civil Service Health Division as assistant supervisor of nursing councellors in 1947. In 1953, she became chief nursing advisor, which involved directing the nursing counsellor service for public servants in the national capital area.

Following graduation, Miss Gordon was nursing supervisor at The Winnipeg General Hospital and at the same time engaged in studies at Manitoba Medical College.

In 1937, she joined the Victorian Order of Nurses and remained on their staff until she came to the Department of National Health and Welfare.

Corazon Ignacio (B.Sc.N., U. Santo Tomas, Manila, Philippines) has been named inservice education coordinator at St. Elizabeth Hospital in North Sydney, Nova Scotia. Mrs. Ignacio comes to St. Elizabeth's after one-and-one-half years as head nurse at Ottawa General Hospital. She had previously worked in hospitals in Cincinnati and Cleveland, Ohio, as staff nurse and operating room nurse.



Helen Cunningham (Reg.N., Ottawa Civic H.; B.N., McGill U.) recently was appointed director of nursing services at Ottawa Civic Hospital. Miss Cunningham has spent most of her nursing career at Ottawa Civic Hospital. Previous to her present appointment, she was associate director of nursing service. She has also worked at the Civic as a staff nurse, assistant head nurse, head nurse, clinical instructor, and executive assistant to the assistant director of nursing.



Margaret C. Cahoon (Reg.N., Women's College H., Toronto; B.A., Queen's U.; Cert.Ph., B.Ed., M.Ed., U. Toronto; Ph.D., U. Michigan) has been appointed associate professor in the school of nursing and the school of hygiene at the University of Toronto. Dr. Cahoon had been assistant professor in the School of Hygiene, University of Toronto since 1963 and visiting lecturer to the School of Nursing, University of Toronto since 1961.

She began her nursing career as a public health nurse for the Board of Health in Picton, Ontario. She then worked as a public health nurse for the Ontario Cancer Research and Treatment Foundation in Kingston, Ontario. Dr. Cahoon then moved to Toronto to become a fellow in public health and subsequently an associate in health education at the School of Hygiene, University of Toronto.

Dr. Cahoon has been active throughout her nursing career in the Registered Nurses' Association of Ontario, serving on various executive committees. She was a World Health Organization Fellow from 1963 to 1964. □

dates

April 14 - May 9, 1969
May 12 - June 6, 1969
Rehabilitation Nursing Workshops, University of Toronto. Four-week course for R.N.s employed in acute general and chronic illness hospitals, nursing homes, public health agencies, and schools of nursing. Tuition fee: $150. Apply to: Division of University Extension, Business and Professional Courses, 84 Queen's Park, Toronto 5.

April 20, 1969
Second Annual Dialysis Symposium for Nurses, held in conjunction with annual meeting of American Society for Artificial Internal Organs, at Chalfonte-Haddon Hall, Atlantic City, New Jersey. Organized by the US Public Health Service's Kidney Disease Control Program. For further information write: Michael A. Byrnes, Information Services Section, Dept. of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, 4040 North Fairfax Dr., Arlington, Virginia 22203.

April 28 - May 2, 1969
Final workshop of the Extension Course in Nursing Unit Administration, Regina, offered in English and French to registered nurses in administrative positions who are unable to attend university. Sponsored by the Canadian Nurses' Association and the Canadian Hospital Association. Write to: Director, Extension Course in Nursing Unit Administration, 25 Imperial Street, Toronto 7.

May 1-3, 1969
Registered Nurses' Association of Ontario, annual meeting, Royal York Hotel, Toronto.

May 5-7, 1969
Workshop for teachers on test construction, conducted by Professor V. Wood, School of Nursing, The University of Western Ontario. Theme: Task-oriented work sessions on essay questions, models for marking essay questions; objective examinations and item-writing practice sessions; and final assessment of student nurses. Send applications to: Miss Angela Armitt, Summer School and Extension Department, The University of Western Ontario, London, Ont.

May 5-7, 1969
Association of Registered Nurses of Newfoundland, annual meeting, Auditorium, Nurses' Residence, Western Memorial Hospital, Cornerbrook.

May 12, 1969
Alumnae Association of the Toronto General Hospital School of Nursing, 75th anniversary. Events for the week of May 12 include tours of the new school and residence, graduation exercises, and dinner at the Royal York Hotel. For dinner tickets ($8.50) and further information write: Mrs. Grieg Brown, 27 Thorncliffe Park Drive, Apt. 301, Toronto 17.

May 12-14, 1969
St. Boniface School of Nursing, Manitoba, class of 1944 will hold its 25-year reunion. For information write Mrs. M. Gydé, 13 Pawnee Bay, St. Boniface 6, Man.

May 13-16, 1969
Alberta Association of Registered Nurses, annual convention, Macdonald Hotel, Edmonton, Alberta.

May 19-23, 1969
National League for Nursing, 1969 convention. To be held in Cobo Hall, Detroit, Michigan. Fee: NLN members, $15; non-members, $25. Write to: NLN, 10 Columbus Circle, New York, N.Y. 10019.

May 20-23, 1969
Canadian Public Health Association annual meeting, Hotel Nova Scotian, Halifax. Theme: The child in contemporary society. Write to: Canadian Public Health Association, P.O. Box 2410, Halifax, N.S.

May 21-23, 1969
Saskatchewan Registered Nurses' Association, annual meeting, Bessborough Hotel, Saskatoon.

May 21-23, 1969
Registered Nurses' Association of British Columbia, annual meeting, Bayshore Inn, Vancouver. Write: RNABC, 2130 W. 12th Ave., Vancouver 9.

May 23-25, 1969
Reunion of Moose Jaw Union Hospital Alumnae Association, Moose Jaw, Sask. Members of all classes 1909-69 are welcome. Write to: Alumnae Reunion Committee, c/o Mrs. A. Kitts, 870 Stadacona St., W., Moose Jaw, Sask.

May 28-29, 1969
Registered Nurses' Association of Nova Scotia, annual meeting, Yarmouth.

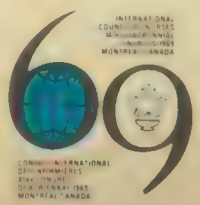
May 28-30, 1969
The New Brunswick Association of Registered Nurses, annual meeting. New Brunswick Hotel, Moncton.

May 29-30, 1969
Manitoba Association of Registered Nurses, annual meeting, Brandon General Hospital School of Nursing Building, Brandon.

June 1-13, 1969
8th Annual residential summer course on alcohol and problems of addiction, Trent University, Peterborough, Ontario. Cosponsored by Trent University and the Addiction Research Foundation of Ontario. Enrollment is limited to 80 persons. The $250 fee includes meals, tuition and accommodations. Write to: Summer Course Director, Education Division, Addiction Research Foundation, 344 Bloor St. W., Toronto 4.

June 16-18, 1969
Conference on nursing education for visitors to the International Council of Nurses Quadrennial Congress. Sponsored by the school of nursing and alumni association, University of Toronto. June 19-20: tours in Toronto and environs to be arranged at request of persons attending conference. Apply to the Secretary of the School, University of Toronto School of Nursing, 50 St. George St., Toronto 5.

June 22-28, 1969



International Council of Nurses' Quadrennial Congress, Montreal. Fee: $60. Write to: ICN Congress Registration, 50 The Driveway, Ottawa 4, Ont. □



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Safety features include: apnea alarm system, adjustable maximum pressure relief valve, and low-pressure alarm to indicate system leaks.

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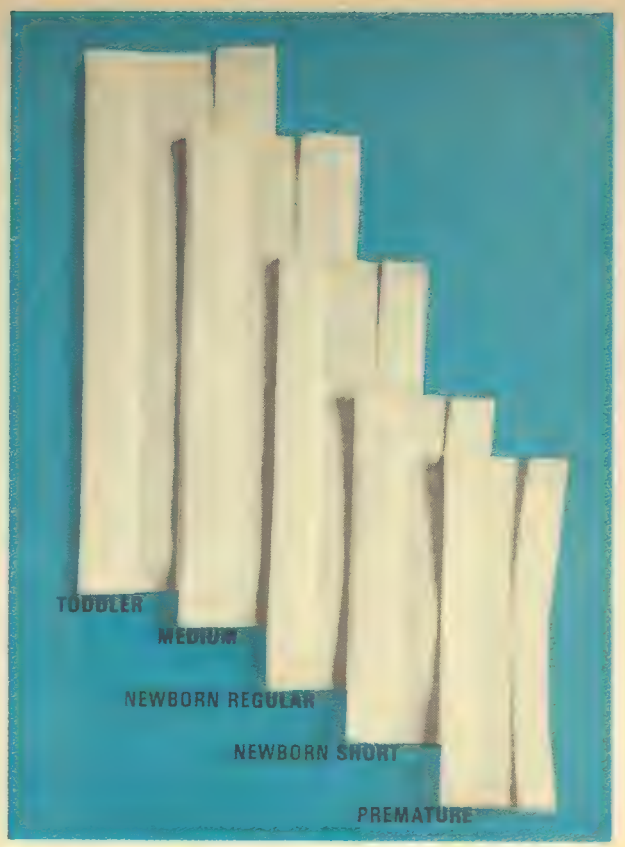
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Safety Not In Numbers

A good samaritan is most likely to be a single samaritan, rather than one of a crowd, according to an American study reported in *The Horner Newsletter.*

People in public are afraid to "lose their cool," particularly when they are in a crowd. Also the attitude: Nothing can be wrong, otherwise someone would try to stop it, was given as a reason for increased violence occurring without anyone nearby trying to stop it.

Patients Became Gourmets

A Russian proverb that goes "Drink a glass of wine after your soup, and you steal a ruble from your doctor," has the support of doctors, as well as patients, at San Francisco's St. Luke's Hospital. An article in the Bulletin of the Society of Medical Friends of Wine reports the success of an experiment that began at the hospital in 1961, with the arrival of a chef from a famed restaurant. The purpose: to tease the patients' appetites with the "arts of haute cuisine developed by great culinary artists." The results: "Impressive therapeutic benefits to the patients, as testified to by their physicians."

Women and Water

Women use water in many places for many things – but not to drink, says Dr. William F. Mengert, commenting on day-to-day problems of obstetrics and gynecology in the *Practical Ob. Gyn.*

The reason for this, says Dr. Mengert, is that in our culture it is easier for the male to find a place to empty his bladder than for the female. Consequently, a woman has learned to be sparing in her water intake.

Dr. Mengert insists on his private patients drinking a minimum of 12 glasses (3 quarts) of water a day.

Among the many feminine ills that can be cured by this "cheap and excellent medicine," is cystitis, a frequent complaint of many women.

The conclusion of this watered-down version of Dr. Mengert's article, in his own words is: Sell it to her, doctor, sell it to her!

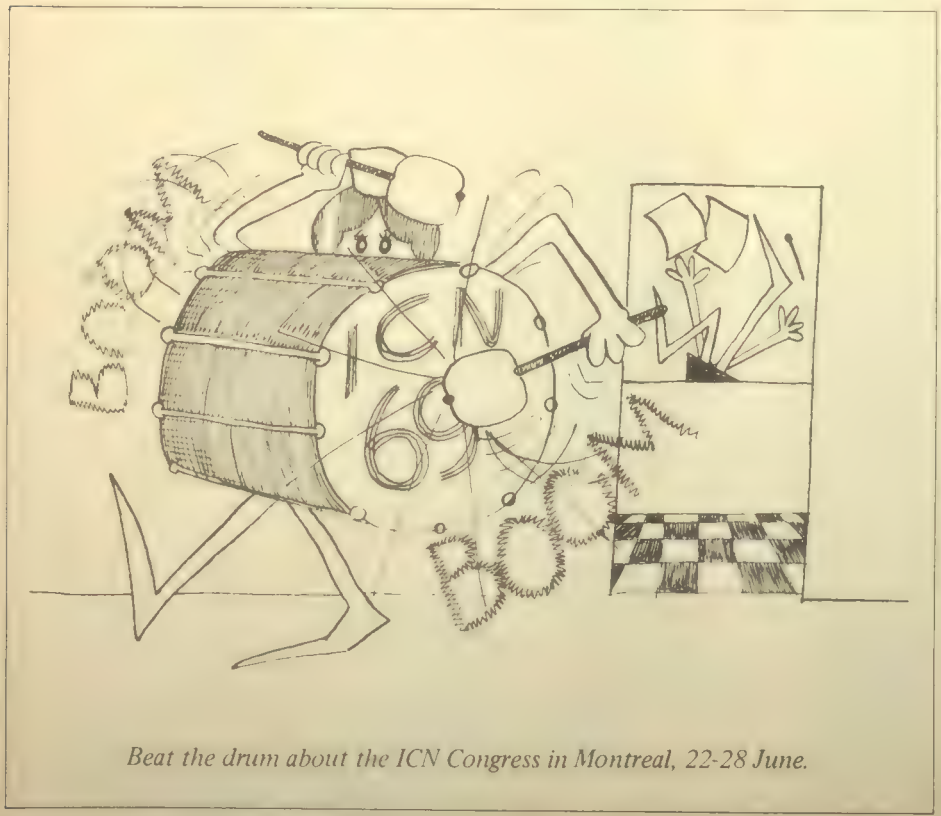
Noisy shoes

How many hospital personnel realize they are guilty of wearing noisy shoes?

Harriet Faulkner of Mission, B.C., who was a recent daily visitor for six weeks in a large hospital, found it interesting to notice the number of noisy shoes worn by hospital personnel.

Some of the offenders were student nurses, though the visitor didn't blame them. She asks if the manufacturers of white duty shoes are not aware of the need for soft leather soles and heels. And surely, she says, schools of nursing do not advocate hard-soled shoes!

It is to be hoped that the kicks will go to the guilty parties, so that future hospital visits will be more pleasant to the ear.



Beat the drum about the ICN Congress in Montreal, 22-28 June.

Talking back

"Talking back" is a term loaded with connotations of unruly behavior and smart alecky, disobedient children; "feedback," on the other hand, connotes the sterile, efficient, controlled world of the computer. Both words mean essentially the same, however, and psychology and art students at the University of Cincinnati are benefitting from an electronic device in their classroom that enables them to "talk back" to their lecturer.

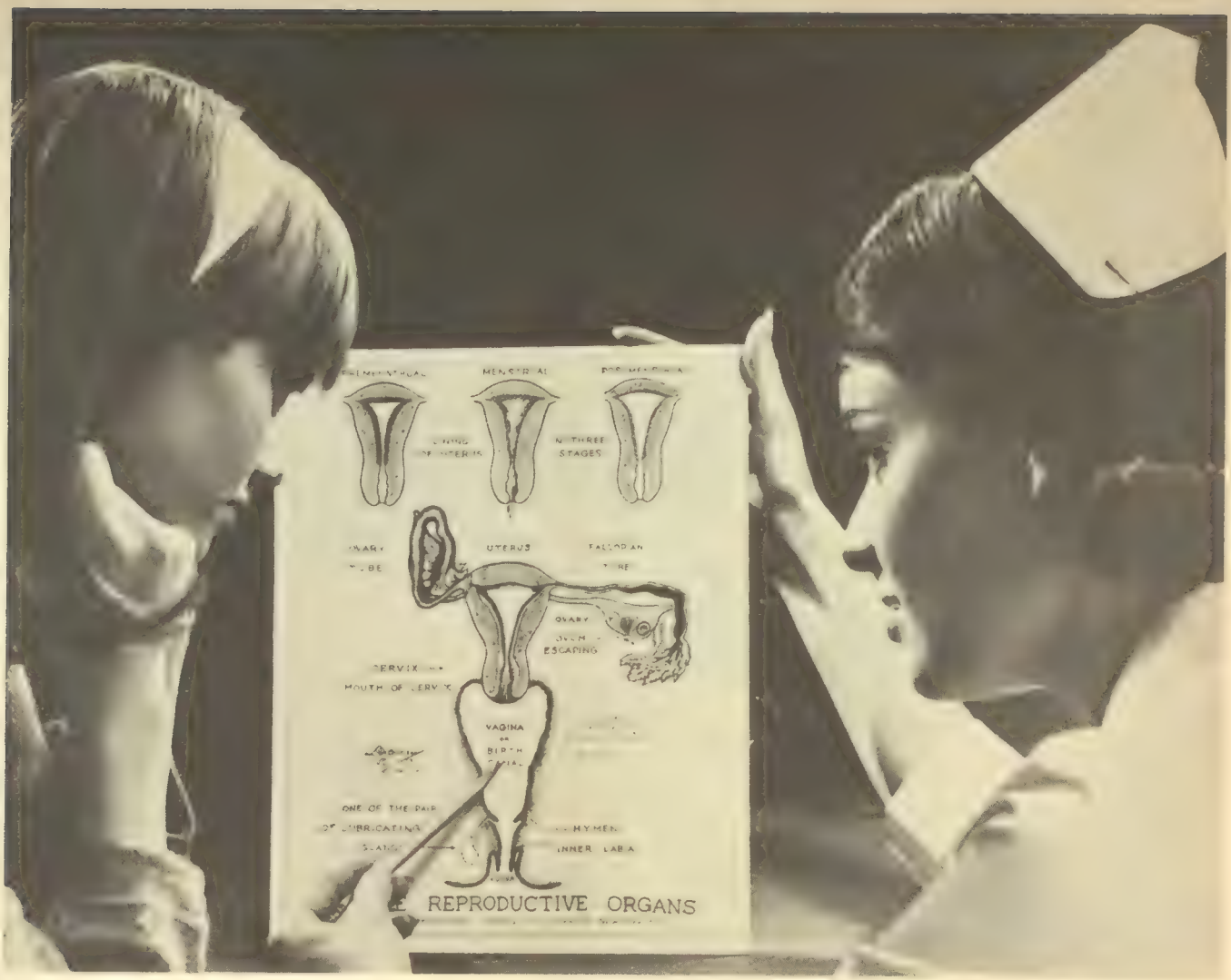
The students let their feelings be known by signalling to their instructor with red and green lights. A monitoring device with blinking colored lights, called a communicator, is located at the front of the classroom. Wires lead from the monitor to switches controlled by the students.

"When students become frustrated with a lecture or feel 'lost' or just plain bored," a psychology instructor at the University of Cincinnati, Dorelle Heisel, explained, "they can indicate their anxiety by signalling me on the monitor."

An instructor can determine the mood of his class and ultimately the effectiveness of his teaching by specified combinations of blinking lights, Mrs. Heisel continued. "It has been found that only about 20 percent of a lecture class is listening at any one time. The lecture, however, is a valuable medium for communicating information. This 'communicator' can increase its effectiveness by permitting students to influence an explanation while it is in progress."

As she sees it, the communicator will sensitize instructors to student reactions and involve students in the class, since they've helped shape it.

David Cox, a specialist in training development at Proctor & Gamble, developed the communicator.



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Some teen-agers have heard they shouldn't bathe or wash their hair during their menstrual periods. Some think unmarried girls shouldn't use tampons. Others say exercise brings on "cramps." No wonder they call it the "curse."

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References: 1. Beck, J.W., Saavedra, D., Antell, G.J., and Tejeiro, B.: Am. J. Trop. Med. **8**:349, 1959. 2. Sanders, A.I., and Hall, W.H.: J. Lab. & Clin. Med. **56**:413, 1960.

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Nursing assistants are here to stay

Dorothy J. Kergin, Reg.N., Ph.D.

Society has granted to nursing the right to determine the conditions for attaining and retaining membership in the profession, through control of the conditions for registration as a nurse. To be identified as a profession also implies that nursing exerts a measure of control over the manner in which its services are rendered. In return for both, nursing is responsible to society for providing its services as effectively and as efficiently as possible. Whenever a profession proposes a change in its educational standards for entry, in the conditions for remaining, or in the manner in which its services are rendered, it must ask itself if these changes are in the best interests of society as a whole.

Nursing is not fulfilling its responsibility to society if it advocates that educational programs to prepare practical nurses or nursing assistants be discontinued. At the Canadian Nurses' Association's 34th general meeting in July 1968, delegates approved a recommendation of the Committee on Nursing Education that "all programs which prepare practitioners, who, upon graduation are not eligible for licensure as registered nurses, be phased out," adding only the word "gradually" to the original recommendation.*

Since the proposal is directed toward nursing assistant programs, it must be considered ill-conceived and poorly timed. A decision such as this, which has profound social and economic effects for society and for nursing, should be based upon a scientific study, or at least upon a careful assessment of all the factors involved. There is no real evidence that the CNA has done this.

The proposal lacks rationality for the following reasons:

1. *It does not address itself to the problem of more effective utilization of the nurse.* All individuals who are incapacitated by illness, injury, or senescence do not require personal care from a registered nurse. Many patients confined by disability to the home, hospital, or nursing home can be maintained and moved toward rehabilitation through the ministrations of someone with lesser preparation than that required for registration as a nurse. This assumes, of course, that a professional registered nurse assesses the patient's needs for nursing care, formulates a plan for this care – indicating the level of skill required to expedite it – and periodically evaluates the progress made by patient and family.

Let us not try to eliminate a category of personnel, but, rather, let us refine the criteria with which a professional nurse can judge what level of skill is required to provide therapeutic nursing care.

2. *The proposal does not recognize the public's concern for the rising costs of medical care services, for both in-hospital and extra-hospital care.* A major part of the nursing profession's responsibility for insuring that its services are rendered efficiently as well as effectively is concerned with the optimal utilization of lesser skilled personnel. Can the public afford to pay, or will it pay, for high cost professional nursing services when lower-priced non-professional services can adequately meet many of their requirements for nursing service? Indeed, how well have we documented the need for professional nursing care at the patient's bedside?

3. *The proposal does not appear to recognize that the health care industry is one of the largest industries in Canada.* At a time when many occupational fields require individuals to have preparation beyond secondary school, the health field continues to offer opportunities for those who have not attained this level. Discontinuing nursing assistant programs would mean that a satisfying work role was denied a number of Canadians who had not had full educational opportunities.

The Canadian Nurses' Association has forthrightly spoken out against recruiting nurses to Canada from countries where there is a real shortage of nursing personnel. Instead of recruiting nurses, why cannot this nation recruit individuals who lack the educational prerequisites to enter nursing but who would qualify to enter a nursing assistant program? These individuals would thereby enter a useful occupation and share the pleasures of life in our democratic society.

4. *The elimination of the formal educational programs that prepare nursing assistants would fail to do away with this level of nursing personnel.* The responsibility for educating nursing assistants would be left to the institutions that employed them. Not only would this contribute to the costs of patient care but it would also lead to educational programs planned by institutions to meet their unique and present requirements for staff.

What is the answer? Where should the Canadian Nurses' Association be directing its influence? Let us, as Association members, encourage projects that attempt to define more clearly the roles and responsibilities of all levels of nursing personnel, to examine present nursing practice and identify what functions the nurse should legitimately perform in the changed world of tomorrow, and to consider how nursing can contribute most effectively to the delivery of health care. We cannot turn back time – the nursing assistant is here to stay. If we do not determine how best she can be utilized, others will do it for us.

The Canadian nursing profession has a right to expect that the Canadian Nurses' Association policies will be loudly proclaimed and broadly interpreted to influence health policies and practices. Any proposal such as this one that contravenes the realities of today and tomorrow may well weaken the profession's influence among employers and in society at large.

* Identity and Destiny – in Saskatoon, *Canad. Nurs.*, 64 33, Aug. 1968.

Dr. Kergin is Associate Director, McMaster University School of Nursing, Hamilton, Ont.



And now your income tax...

A few general rules of the game and some specific details that are of interest to nurses.

Frederick S. Mallett, C.A.

By April 30, 1969 over seven million Canadians are expected to file personal tax returns for the year 1968. The federal government has estimated that these returns will produce personal income tax revenue, including old age security tax, of approximately $4.2 billions. In addition, the federal government will collect over $1 billion in income taxes on behalf of the provinces other than Quebec. (All provinces impose a personal income tax on its residents; Quebec alone administers and collects its own provincial income tax.) Although these rough figures may be too large to convey any personal impact, most taxpayers have found that their share of this total represents a significant personal sacrifice.

Over the years, the Canadian tax system has been amended many times to correct obvious inequities and to provide a number of special incentives. Taxpayers who wish to take advantage of these provisions to minimize their tax liability or to defer the payment of tax until some future time should, therefore, have some understanding of these rules and plan their financial affairs accordingly.

It is not possible to outline here all of the rules applicable to every individual taxpayer. There are, however, a number that are of general application and these, together with more specific details of particular interest to members of the nursing profession, are the subject of this article.

Who is taxable?

Generally, Canadian income tax is imposed upon the world income of persons resident in Canada at any time in the year. Citizenship is not a determining factor in establishing liability for Canadian tax and, in this respect, Canadian practice differs from that of the United States, which imposes tax on all US citizens, wherever resident. The first problem that may face a taxpayer, therefore, is whether or not he is resident in Canada and, if so, for what period.

Since the solution to this question frequently requires reference to a mass of court decisions, legal advice may be required. In the simple case, however, a person is normally resident in the place where he has his usual home and where he is employed or carrying on a business or profession. Canadian citizens who are living and employed in Canada are, therefore, subject to Canadian tax. Immigrants, however, are subject to Canadian tax on their world income earned only in the period of their residence in Canada. Similarly, persons giving up their Canadian residence, although not necessarily their Canadian citizenship, are subject to Canadian tax only on income received during the period prior to their departure.

Persons subject to Canadian tax for part of a year only are not entitled to the full personal exemptions provided in the Income Tax Act, but rather to a pro rated exemption based upon number of days' residence in Canada. It is beyond the scope of this article to deal further with the complex problems that may face non-resident taxpayers. The following discussion is therefore aimed at the great majority who are resident and employed in Canada throughout the year.

Two classes of personal taxpayers

There are two distinct classes of taxpayers and the rules determining income are somewhat different for each class. Most taxpayers are classed as *employees*, and generally the determination of their income subject to tax is fairly simple. Normally employees may use the abbreviated tax return form T1 Short provided they are not engaged in other business activities or earn over $2,500 in investment income.

Self-employed persons, and this class would include private duty nurses, are subject to tax on their net income after deducting expenses necessary to their business or profession. These persons must use the T1 General return. All taxpayers are subject to the same rules with respect to investment income, personal exemptions, medical expenses, and charitable donations, and, of course, to the same rates of tax.

The task facing employees in computing their liability for tax is simplified by

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the reporting requirements of the Income Tax Act, which imposes upon the employer an obligation to furnish each employee with a summary of earnings for the year, the amount of tax deducted at source, and the amounts of contributions to registered pension plans and to the Canada or Quebec Pension Plan. Each employee should receive two copies of this report (form T4) before the end of February. Other copies are provided by the employer to the Department of National Revenue for checking purposes.





Self-employed persons must maintain their own accounting records to establish income received in the year and expenses incurred in earning income that may be deducted for tax purposes. Generally, individual taxpayers must compute income and expense on a cash basis, that is, on cash actually received or actually disbursed during the year.

Income from employment that is subject to tax includes salary as well as the value of board, lodging, or any other benefit received by virtue of employment. There are, however, certain benefits that are specifically excluded, such as employers' contributions to pension plans, group sickness or accident insurance plans, medical plans, and payments under group term life insurance policies.

Employees are entitled to very few deductions in computing their income other than minor amounts for annual fees paid to professional associations. This general restriction prevents, for example, a nurse employed in a hospital from deducting the cost of uniforms that she has been required to purchase herself. However, if a nurse is provided with uniforms by her employer without charge, the Department does not require that the value of this benefit be included in income. A self-employed nurse is entitled to deduct the cost of uniforms in computing her professional income.

Employees generally may not deduct automobile expenses or other transportation costs, since it is assumed that the cost of getting to and from work is a personal responsibility. If an employee is required to use an automobile in the performance of his or her duties and is reimbursed on a mileage basis, the reimbursement is not included in income unless the amount received is obviously excessive.

Some employers prefer to give lump sum car allowances that are not directly related to actual business use. In these cases the allowance can be included in income but a deduction may be claimed for actual expenses incurred. However, it is unlikely that expenses could be claimed significantly in excess of the allowance given, since the allowance was probably determined by the employer to be reasonable in the circumstances.

Self-employed taxpayers, on the other hand, may deduct transportation costs related to the earning of income. A private duty nurse, for example, should be able to deduct the cost of driving from her home to the places where she renders professional services. In such cases, automobile expenses would include gas and oil, maintenance, tires, insurance, licence fees, and capital cost allowance (depreciation). Depreciation may be claimed at a normal rate of 30 percent of the undepreciated cost of the automobile.

Since automobiles are rarely used entirely for business or professional purposes, taxpayers wishing to claim automobile expenses are required to maintain a mileage log recording the date, mileage, destination, and purpose of each business trip. Business mileage for the year may be determined and expressed as a percentage of total mileage driven. This percentage must then be applied to the total of automobile expenses incurred to determine the amount deductible for tax purposes. Taxpayers must be able to support automobile expenses, as well as other expenses claimed with invoices, cancelled cheques or receipts, although these need not be filed with the tax return.

Income from other sources

In addition to employment or professional income, income from other sources, such as interest, dividends, estate or trust income, the income portion of annuities, and alimony or separation allowances, must be included. Although all amounts are taxable, no matter how small, many taxpayers have apparently failed to report bank interest or dividends unless they have received a T5 slip from the paying source. This year the Department of National Revenue has extended its reporting requirements so that all interest or dividend payments over $10 must be reported. Previously the lower limit had been $100. As a result, many taxpayers may have received T5 slips, which report such minor items as bank savings account interest, for the first time this year.

Taxpayers should not forget to include the value of bond coupons cashed during the year, whether or not a T5 slip has been received, particularly if an information slip (form T600) was filled out as required at the time the coupon was cashed.

The following additional points should be kept in mind when calculating tax on investment income.

1. *Interest:* Interest on bank borrowings may be deducted if the borrowed money was used to purchase income-producing investments or property. Interest may be deducted in such cases even if the amount of interest paid in the year exceeds the amount of income received.

2. *Other Carrying Costs:* Other costs applicable to investment income are deductible, such as safety deposit box rentals, one-half of the fees charged by investment counsel, and, if necessary, professional accounting fees paid during the year.

3. *Depletion Allowances:* Dividends received from companies engaged in extra-active industries, such as mining, oil and gas, may be reduced by depletion allowances at various rates. In most cases, the depletion allowance rate is shown on the T5 slip; if not, the rate may be obtained by calling the local office of the Department of National Revenue.

4. *Twenty Percent Dividend Tax Credit:* Taxes may be reduced by 20 percent of the net dividend income received (that is after deducting applicable carrying costs and depletion) from

taxable Canadian corporations. This credit is intended to offset in part the tax paid by the corporation on its earnings prior to the dividend distribution. But it also serves as an incentive to invest in Canadian equity securities.

Personal exemptions

Every taxpayer is entitled to personal exemptions of varying amounts commencing at $1,000 (unless reduced in the case of part-year residents). Although these exemptions are described in some detail on the return itself, some further explanations may be useful.

Although working wives whose income is over $1,250 may not be claimed as dependents by their husbands, it should be remembered that this limitation



applies only to income received after marriage. Thus, a working girl earning $400 per month who was married on October 15, 1968, could be claimed as a dependent by her husband. In this case the exemption would be $250 ($1,250 less $1,000 earned after the wedding). This newly married woman must also file her own return for the year, reporting income of $4,800 and claiming the basic exemption of $1,000.

When both parents are working, the question is sometimes asked as to which parent may claim the children as dependents. Normally it is advantageous for the spouse with the larger income – usually the husband – to claim the children; because of the progressive tax rate structure, the exemption would result in a greater tax saving. It is, however, a question of fact as to which parent is financially responsible for the children's support and, therefore, in some cases the wife may claim the exemption.

Medical expenses and charitable donations may be claimed subject to certain limitations. Every taxpayer may claim either (a) a standard deduction of $100 or (b) actual medical costs incurred on behalf of the taxpayer and his dependents, less 3 percent of net income, plus donations made to registered Canadian charities.

Medical expenses may be claimed if they were paid during any 12-month period ending in the year, provided, of course, that they were not claimed previously. Medical expenses include amounts paid on behalf of the taxpayer by medical or hospital insurance plans, except amounts paid by provincial hospital insurance plans. In Ontario, for example, supplementary hospital benefits paid by Blue Cross may be claimed, but not amounts paid by the Ontario Hospital Services Commission.

To be deductible, charitable donations must be paid to registered Canadian charities and must be supported by receipts showing the registration number of the organization. There are, however, minor exceptions to this rule covering donations made to certain US charities, if the donor commutes to work in the US or has income from US sources.

After completion, tax returns must be filed on or before April 30 along with a cheque payable to the Receiver General of Canada for any unpaid tax. Many prefer to complete their tax returns as quickly as possible so that they will be processed early. If tax is payable, payment may be deferred until April 30, even though the return has been submitted earlier. If a refund is due, the sooner the return is filed the sooner the refund cheque will be received. Any tax unpaid after April 30 is subject to a 5 percent penalty plus interest.

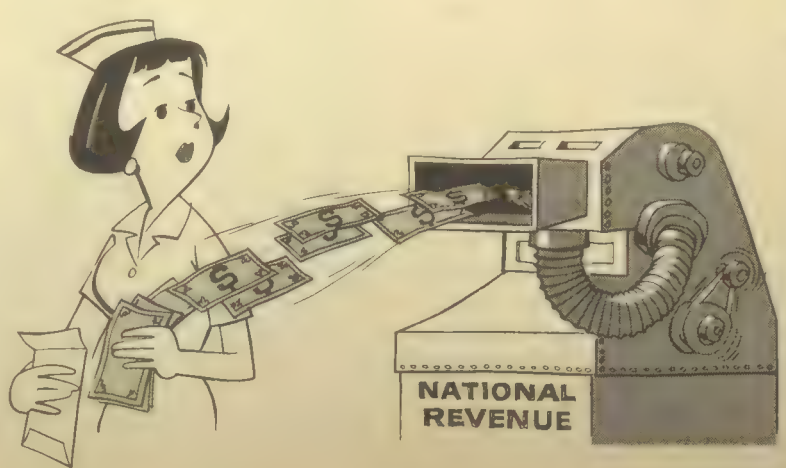
A look at the future

What can be done to reduce tax in 1969? Many taxpayers are unaware of the tax savings (more properly a deferral of tax to some future date) that may be achieved through Registered Retirement Savings Plans. These plans are generally available through insurance companies, trust companies, and mutual funds, and provide a wide variety of investment objectives and other features. Contributions are deductible for tax purposes up to certain prescribed limits. The fund itself is exempt from tax so that the growth rate of the portfolio is higher than would otherwise be possible. Following retirement, benefits in the form of an annuity will be subject to tax, but presumably at a lower rate than would have been paid had the contributions been taxed as earned.

These Registered Retirement Savings Plans are of particular interest to self-employed persons who may not enroll in registered employee pension plans; however employees who wish to set aside more than permitted under their pension plan may wish to use a Registered Retirement Savings Plan as a supplement.

Although further tax saving measures may be applicable in certain circumstances, the reader should understand that the federal government is now in the process of completing a review of the substantial and challenging recommendations made by the Carter Royal Commission on Taxation in 1966. There is some indication that many of the Commission's recommendations may be adopted, at least in modified form, but no precise details are expected to be available until June 1969 at the earliest. In all probability we will have a new Income Tax Act in effect by 1970.

At this stage one can only speculate as to how the new Act will affect the individual taxpayer, other than to suggest that income tax will continue to absorb an increasing proportion of personal income. Therefore, awareness of the impact of taxation remains an important first step in financial planning.



Medicolegal problems can arise in the coronary care unit

A nurse working in a coronary care unit should be aware of all the medicolegal implications involved in the care of her patients, and take measures to protect herself from charges of malpractice.

Gloria G. Crotin, B.N., M.N.Ed.

In carrying out a nursing procedure in any clinical area, a nurse can be sued if damage results to the patient. The action against her would be successful if the damage were caused by negligence on her part. In the coronary care unit, the possibility of the nurse being sued for malpractice is increased, since she often is called on to perform functions that can mean life or death for the patient.

In some coronary care units, particularly those in small community hospitals, there is a danger that the nurse may be required to make emergency decisions and to perform functions that are not entirely nursing in nature. In this event, she could be in difficulty in three areas: 1. She is vulnerable to legal action taken by the patient for malpractice; 2. She is vulnerable to legal action taken by the medical profession in that she carried out an unauthorized practice; 3. If she carries out an unauthorized practice, she could be guilty of professional misconduct within the regulations of the nursing profession.

Problems facing the nurse

A patient is admitted to the coronary care unit with a diagnosis of myocardial infarction, coronary thrombosis, or a suspected heart problem. While in the unit he may or may not develop complications, such as a major cardiac arrhythmia.

A major arrhythmia presents the greatest problem, since it may lead to ventricular standstill or ventricular fibrillation. In either event, *someone* – preferably the doctor, but all too often the nurse – must intervene.

If the doctor is not available when such an emergency arises, the nurse is forced to make an immediate decision concerning her patient's treatment; her decision will depend on her assessment of his condition. Does he have cardiac standstill or cardiac fibrillation?

In this crisis, the nurse may decide to apply external thoracic compression or apply an electrical defibrillator to the heart. She may make a wrong assessment and thus apply an incorrect treatment, such as giving an electrical countershock when it is not indicated, or failing to apply external thoracic compression when it is indicated.

The nurse is faced with another dilemma if the patient goes into cardiogenic shock or cardiac decompensation. If the physician is unavailable, she then has to decide whether vasopressor drugs are required and when. She also has the task of administering these drugs intravenously if a doctor is not present.

Even if the nurse selects the correct course of treatment, damage to the patient may follow. External thoracic

Mrs. Crotin, a graduate of McGill University and the University of Pittsburgh, is now Director of Nursing at York Central Hospital, Richmond Hill, Ontario.



compression may be accompanied by damage to the heart, such as a contusion of the myocardium, rupture of the heart or liver, or fractured ribs with possible lung penetration. The use of vasopressor drugs, such as metaraminol bitartrate can lead to severe tissue damage if the medication inadvertently extravasates.

Protective measures

A review of law cases reveals few charges against nurses who have expanded their functions into the area of general medical practice, and few charges against physicians who have delegated to nurses functions that are beyond the education of a nurse. However, this does not lessen the importance of the nurse being protected against lawsuit.

Many of the protective devices used in the past are outdated and need to be revised, if they are to provide legal protection. For example, some provincial nursing acts do not define nursing practice; in addition, few medical or hospital associations have issued statements of policy in conjunction with the provincial nurses' association to support the nurse's activities in the coronary care unit.

Nursing Practice Act: Every province in Canada has its own nursing act. These acts, which are designed to protect the public by demanding certain responsibilities from the nurse, usually provide a definition of professional nursing; a few, however, do not. The acts grant minimal rights to the nurse, such as the placement of the initials RN following her name. Most of the acts permit the nurse to do almost anything in the medical area as long as it is prescribed by a physician or done under his direction or control.

A definition of professional nursing practice is essential, for it limits the area of professional nursing and protects the nurse from the charge of unlicensed practice of medicine, if she performs only those functions that are defined by the act.

The statutory definition of nursing within any province may determine a nurse's responsibility for injury to a patient. For example, questions of reliability for damages may relate to the nurse's power of observation of symptoms, such as the observation of a patient going into cardiogenic shock. Reliability questions may arise from the recording of facts. The nurse may record a wrong pulse rate or electrocardiographic reading. She also runs into problems if she fails to carry out prescribed treatments and medications, such as those suggested for ventricular fibrillation. The nurse is also responsible for safeguarding the patient's safety.

The tendency for the courts is to follow past issues or similar rulings in other provinces for malpractice suits brought against a nurse. These comparable rulings may persuade a judge, but any decisions in the future that involve a nurse in a coronary care unit will probably be based on the nurse's educational background and preparation, how she carried out a given procedure, and whether this procedure was within the framework of the hospital's policies and the physician's instructions.

Joint Statements: Further protection for the nurse working in a coronary care unit may be provided by the issuing of a joint statement on the nurse's functions by various professional associations. For example, the California Medical Association, California Nurses' Association, and the California Hospital Association issued a joint policy statement as follows:

"We recognize the propriety of registered nurses to use monitoring, defibrillation, and resuscitative equipment and to institute immediate life-saving corrective measures, if a licensed physician is not immediately available to do so and the following conditions exist: 1. The registered nurse has had special competent instruction in the techniques. 2. The registered nurse performs the authorized procedures upon: (a) the direct order of a licensed doctor of medicine, or (b) pursuant to standing procedures established as set forth in item 4. following. 3. Where a hospital has determined that a registered nurse may perform the techniques, then the techniques to be performed within the framework of designated preparation and practice of the nurse shall be established for the hospital by a committee composed of representatives from the medical staff, the department of nursing, and the administration. Thus the framework of preparation and practice shall be reproduced in

writing and made available to the total medical and nursing staffs. 4. Such criteria shall make provision that in case of a cardiac emergency, a licensed physician and other designated categories of personnel are to be immediately summoned to assist the registered nurse who is carrying out the physician's orders or is carrying out standing procedures established by the medical staff of the hospital, and contained in the adopted criteria."[1]

Malpractice Insurance: The nurse in a coronary care unit should purchase a malpractice insurance policy. The usual policies provide her with two benefits. First, the insurance company bears the cost of defending and representing her in court. Second, most liability policies state that the insurance company will pay for all losses incurred by the nurse, including settlements made out of court, up to the face value of the policy.

In some countries registered nurses can purchase professional liability insurance through their professional nurses' association. The maximum limit is from one to two hundred thousand dollars payable on each claim, with a limit on the number of claims in one year.

Future problems

It is quite likely that nurses may soon be involved in establishing the time of death of a patient. Clinical death occurs when there are no observable or perceptible vital signs of life, such as heart beat, respiration, and, in rare instances, brain wave activity. Within an interval of time after clinical death, usually three or four minutes, it is possible in some instances to restore respiration and heart beat through the use of external heart massage, artificial respiration, and drugs. This all must be done before irreversible brain damage occurs. The nurse now records the time of clinical death (cardiac standstill) and the physician records the time of medical death.

The mechanical failure of any of the various monitoring devices that assist in sustaining life, such as the deliberate interruption of a pacemaker or a negligent interruption of the pacemaker that results in death, may present legal problems. Failure to provide competent resuscitative procedures after clinical death may lead to further legal problems.[2]

While nurses are becoming familiar with external cardiac massage and the use of cardiac defibrillators, physicians and researchers are busy developing new heart drugs and advanced equipment. What problems these will bring is not known, but some surmises can be made.

For the treatment of cardiogenic shock, an intra-aortic balloon is already being tested.[3] The balloon, which contains helium, assists the heart by acting as a pump. It is predicted that future coronary artery disease patients may have this balloon inserted immediately upon admission to the coronary unit. There is a major hazard with the balloon: if it bursts, it may cause an embolus.

Another device is the solo hyperbaric chamber or unit.[4] This is a single bed unit capable of delivering high concentrations of pure oxygen. Physicians believe they can halve the death rate from acute myocardial infarctions with the use of this apparatus. It, too, is not without hazards.

A safe environment

When working in a coronary care unit, the nurse should assure herself that she is practicing within an environment that is safe for herself as well as for the patient.

- Each registered nurse should have her own liability insurance policy.
- Records showing monthly equipment checks for conductivity and correct grounding should be kept by the engineering department.
- Nurses' notes should be descriptive and frequent. The time of observations, treatments, and electrocardiograph readings is extremely important.
- There should be written policies on the procedures to be followed when cardiac arrest or any other problem occurs. The policies should be developed by means of a coronary unit committee with registered nurses represented. The committee should meet on a regular basis to discuss current problems and to assure continuing education of physicians and nurses.
- The advanced education and preparation of the nurses who work in the unit should be recorded for future reference. Any additional continuing education should be recorded also.
- The nursing practice act for each specific province should be reviewed to find out if the nurse is practicing within the definition of nursing practice or if she is practicing medicine.
- The nurse should look for the support of various professional organizations and joint statement policies by these organizations and joint statement policies by these organizations on cardiopulmonary resuscitation and other life-saving measures she may be confronted with in the unit.

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Smoking habits of Canadian nurses and teachers

Although the proportion of nurses and teachers who smoke habitually is lower than that of the national average, those who do have the habit smoke more heavily than other Canadians.

A.J. Phillips, Ph.D.

"I don't smoke. Top speed requires top condition," says Al Pease, Canadian racing driver. "Smoking and sports don't mix," says Elaine Tanner, one of Canada's top swimmers. Nancy Greene, Olympic and World Champion skier, says simply: "I don't smoke."

Personality posters displaying testimonials such as these along with a photo of the star in action are distributed by the Canadian Cancer Society as part of their campaign against smoking. They are aimed particularly at young people, who are known to be greatly influenced by persons they respect or admire.

Whether doctors, nurses, and teachers live up to the expectations of the general public or not, there is no doubt that Canadians think that these persons should be above reproach in matters of health and morals. The example shown by a single doctor, nurse or teacher can make the difference between a nonsmoker starting to smoke or not and a seasoned smoker giving up the habit or continuing it. As far as smoking is concerned, however, doctors certainly do not act as examples to the rest of the population. A recent survey of doctors' smoking habits revealed that about one out of three smoke cigarettes regularly and that doctors smoke, on the average, considerably more cigarettes per day than cigarette smokers among the rest of the Canadian population.[1]

The following study of Canadian nurses and teachers was carried out to discover how their smoking habits compare with those of other Canadians.

Fewer nurses and teachers smoke

Each provincial registered nurses' association was invited to select every thirtieth name from the mailing list, beginning with the seventh name. All 10 provinces agreed to participate. A covering letter, questionnaire, and self-addressed envelope were sent to 3,557 nurses, and 1,901 (53 percent) submitted completed questionnaires.

Each provincial teachers' association was invited to select every 100th name from its mailing list, beginning with the seventh name. All provinces with the exception of British Columbia agreed to participate. The necessary materials were sent to 1,227 teachers, and 792 (64 percent) submitted completed questionnaires.

The first question asked was, "Would you classify yourself as a smoker, ex-smoker, or nonsmoker? " The results as shown in Table 1 were: 28.7 percent of nurses and 29.2 percent of teachers classified themselves as smokers; 14.9 percent of nurses and 12.2 percent of teachers classified themselves as ex-smokers; and 56.4 percent of nurses and 58.6 percent of teachers were nonsmokers.

A study conducted by the Dominion Bureau of Statistics for the Department of National Health and Welfare revealed that 35.6 percent of Canadian women and 59.6 percent of Canadian men over 20 years of age smoke cigarettes.[2] It would appear, therefore, that the proportions of nurses and teachers who are cigarette smokers are below that for Canada.

Of the 545 nurses who classified themselves as smokers, 504 or 92.6 percent reported smoking cigarettes regularly, and 257 (90.8 percent) of the 283 who classified themselves as ex-smokers, said that they used to smoke regularly. Among teachers, 207 (89.6 percent) of 231 smokers smoked cigarettes regularly, and 89 (91.8 percent) of the 97 ex-smokers had done so.

Of nurses who smoked at one time, 34.2 percent had given up smoking, and 29.6 percent of teachers who smoked at one time had given up the habit. As shown in Table II, approximately one-quarter of nurses and teachers have decreased their daily consumption. Offsetting this, however, is 24.7 percent of teachers and 14.8 percent of nurses who have increased their daily consumption.

More heavy smokers

Table III shows an analysis of the average number of cigarettes smoked per

Dr. Phillips is Assistant Executive Director (Statistics) at the National Cancer Institute of Canada in Toronto.

day and indicates that heavy smoking – over 20 cigarettes per day – is more common among nurses and teachers than among the rest of the Canadian population. Whereas 9.9 percent of Canadian men and 4.3 percent of Canadian women smoke more than 25 cigarettes daily, 30.3 percent of teachers and 31.7 percent of nurses smoke more than 20 cigarettes per day.[3]

As shown in Table IV, a little more than one-third of nurses and teachers gave up smoking because of scientific evidence that smoking is injurious to health; about one out of eight nurses and one out of five teachers gave up smoking to relieve respiratory ailments; and about one out of 12 nurses and teachers stopped smoking because of illness.

Not setting example

This study of a random sample of nurses and teachers in Canada revealed that 28.7 percent of nurses and 29.2 percent of teachers smoke cigarettes. In view of the mass of scientific evidence relating cigarette smoking to cardiovascular and bronchopulmonary disease, and the unique position of members of these professions as examples to others, it is difficult to understand why such high proportions continue to smoke cigarettes. The continuance of the habit indicates that many are not fulfilling their roles as models to their patients and students.

There is evidence also that heavy cigarette smoking is more common among both nurses and teachers than among the general population. In the present study, only 20.7 percent of nurses who smoke and 21.6 percent of teachers who smoke consume fewer than 10 cigarettes daily; the Canadian study showed that this figure is 27.8 percent for the population at large. Conversely, 31.7 percent of nurses who smoke and 30.3 percent of teachers who smoke consume over 20 cigarettes per day, compared to 7.8 percent in the Canadian study (based on more than 25 cigarettes per day).

The study shows a decrease in cigarette smoking among both groups; 34.2 percent of nurses and 29.6 percent of teachers who smoked cigarettes at some time have stopped. Approximately 40 percent of the participants said that they stopped smoking because of the scientific evidence that cigarette smoking is hazardous to health. However, about 22 percent of nurses and 30 percent of teachers were under some pressure to give up the habit, as reflected by those who mentioned relief from respiratory symptoms or illness.

Although a proportion of nurses and teachers has given up cigarette smoking, out of every three nurses and teachers who still smoke, one smokes more than 20 cigarettes a day. It is clear that neither of these professions can hope to influence other Canadians to give up smoking.

TABLE I

Classification of Nurses and Teachers by Smoking History

	Nurses		*Teachers*	
Smoking History	No.	%	No.	%
Smoker	545	28.7	231	29.2
Ex-smoker	283	14.9	97	12.2
Nonsmoker	1,073	56.4	464	58.6
Total	1,901	100.0	792	100.0

TABLE II

Classification of Smokers by Change in Habit

	Nurses		*Teachers*	
Change in Habit	No.	%	No.	%
Decreased daily consumption	156	28.5	58	25.1
Increased daily consumption	81	14.8	57	24.7
No change	237	43.9	99	42.8
Data omitted	71	12.8	17	7.4
Total	545	100.0	231	100.0

TABLE III

Daily Cigarette Consumption by Amount Smoked

			Canada	
Amount Smoked per Day	*Nurses* %	*Teachers* %	*Males* %	*Females* %
Under 10 cigarettes	20.7	21.6	21.8	37.9
10 – 20	31.9	34.2	68.3	
More than 20	31.7	30.3	9.9	*57.8
No Data	15.7	13.9		**4.3

*11 – 25 cigarettes per day
**over 25 cigarettes per day

TABLE IV

Classification of Ex-Smokers by Causative Factor

	Nurses		*Teachers*	
Causative Factor	No.	%	No.	%
(a) Belief in scientific evidence	112	39.6	37	38.1
(b) Relief of respiratory symptoms	36	12.7	21	21.6
(c) Illness	25	8.8	8	8.2
Combination of (a) and (b)	28	9.9	14	14.4
Combination of (a) and (c)	3	1.0	4	4.3
Combination of (b) and (c)	1	0.4	–	–
No data	78	27.6	13	13.4
Total	283	100.0	97	100.0

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□

Hemodialysis in the home

Artificial kidney treatment in the home offers a new lease on life to many patients with chronic renal failure.

Sheila Wood, S.R.N., S.C.M.

For many patients with chronic renal failure, use of the artificial kidney has meant a definite prolongation of life. Even so, this method of treatment is not without its problems.

First, the cost of operating dialysis units is prohibitive; second, a limited number of beds are available for treating these patients, even though there are now many hospital-based dialysis centers; and third, few trained staff are available to operate these units. Fortunately, these problems are being solved to a certain extent by teaching the patient and at least one member of his family to carry out dialysis in the home.

Program at MGH

Such a program has been in effect at The Montreal General Hospital since August, 1966. We have 21 patients, whose ages range from 14 to 62 years, carrying out their own dialysis in their homes. Four of these patients live in the United States, and three in New Brunswick; the remainder are Quebec residents.

The patient selected for home dialysis is one who has a capable spouse, parent, or other relative willing to undertake the responsibility of working the machine. Ideally, the patient should be in reasonable health apart from the renal failure – although we have found that vascular disease, such as angina, is not contraindicated – be in his own home, preferably a house, and have a job that he can retain even after many absences; in other words, he has to be a useful member of society.

After admission to the dialysis unit at MGH, the patient has an arteriovenous shunt (AV shunt) inserted. When possible, the shunt is inserted into the leg as this gives the patient a greater degree of independence when he begins and completes dialysis. He is in hospital for about three weeks, during which time hemodialysis is begun and a regular routine of twice-weekly treatments established, to give a total dialysis time of about 30 hours weekly.

The patient and his relative are taught to take and record blood pressure and temperature, to observe the shunt for clotting, and to give catheter care. If the patient is well enough at this time, he then learns how to begin his dialysis. The dietitian helps him to make the most of his restricted diet, which usually allows him 60 mg. of protein, 20 Gm. sodium, and 60 mEq. potassium. Fluids are restricted to 400 ml. daily, or free fluids according to the urinary output.

As soon as the patient is mobile, he and his relative come to the unit every day except Sundays for about six weeks. It must be remembered that few patients or their relatives know anything about medical matters, and learning to take and

Miss Wood, a graduate of The Queen Elizabeth School of Nursing, Birmingham, England, is on the staff of the dialysis unit at The Montreal General Hospital.

record a blood pressure is a feat for them. We are fortunate to have three registered nurses among the wives of our patients, and one patient is a doctor. The length of time for patient teaching also depends on the intelligence and confidence of the people concerned.

Every aspect of patient care is taught, from the sterile technique necessary for beginning dialysis to the giving of blood and saline into the venous drip chamber. During the first two weeks, the patient and his relative learn to prepare the tank that contains the dialysate fluid, and to build and sterilize the artificial kidney. The relative observes the nurses on the unit and how they deal with situations as they arise.

At this stage, the patient is usually beginning and ending dialysis himself. Routine monitoring is then taught, and the patient learns what to do when one of the alarms rings. Emergencies, such as a blood leak through the cuprophane membrane or shock due to excessive weight loss, are covered. Each section is repeated as many times as necessary.

During the last two weeks, the patient and his relative carry out the treatment in a completely separate room located three floors from the dialysis unit. This gives them the feeling of being independent, although they are still linked to the unit by telephone and can call a nurse on the unit, if necessary.

Before going home, the patient and his relative are given a multiple-choice question test; after they have successfully passed this test, they return home, accompanied by the nurse who has been teaching them. She stays with them for the first dialysis, after which they are on their own unless they have any special problems.

The patient keeps in touch with the dialysis unit by telephone. He sends specimens of serum, taken before and after his weekly dialysis, to the unit, along with dialysate fluid and whole blood for hematocrit determination. Analysis of these specimens is made at the hospital, and any abnormality is noted by the doctor, who immediately calls the patient.

Every two months the patient returns to the hospital and visits the renal clinic, where he is examined. Here, he has an opportunity to discuss any problem he might have encountered during dialysis.

Patient histories

One of our youngest patients, C.D., is a 15-year-old boy with hereditary nephritis, which resulted in chronic renal failure. There was a strong family history of the disease, so C.D. was discovered early and followed for several years. For two years he was managed on a low sodium diet, fluid restrictions, and drugs, such as Amphojel, calcium, Apresoline Hydrochloride, Aldomet and guanethidine sulphate. He was usually hypertensive (BP 160/100) but managed to feel fairly well. C.D. was followed carefully at clinic; when his blood urea nitrogen (BUN) reached 200 mg./100 ml. and his creatinine 20 mg./100 ml., he was brought into hospital for initiation of hemodialysis. *(Normal BUN:* 10-20 mg./100 ml.; *normal creatinine level:* 0.7-1.5 mg./100 ml.).

Peritoneal dialysis was done first for 57 hours, and this brought his BUN down to 60 mg./100 ml. and removed six pounds of fluid. An AV shunt was inserted and hemodialysis begun. His mother came to learn to run his artificial kidney, and C.D. himself learned to manage the equipment and begin and end dialysis. He is now at home with his dialysis equipment and managing well, after a few initial problems concerning the family's water supply. He goes to school and is showing good progress.

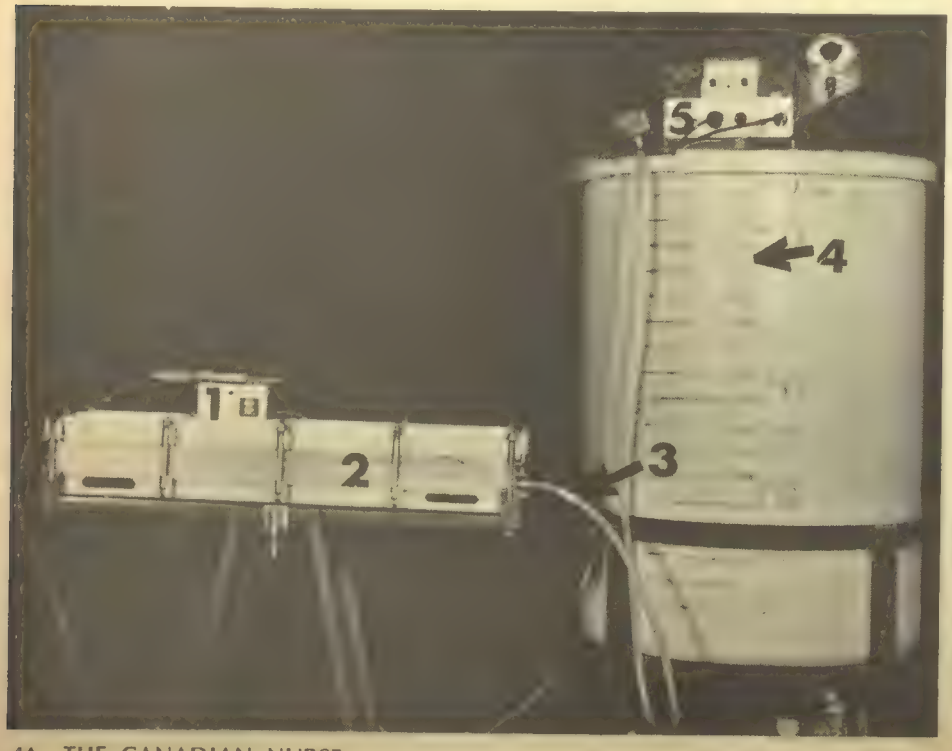
Mrs. P.M., of Vermont, a 55-year-old business woman, has chronic glomerulonephritis. As her disease progressed, it became necessary to begin hemodialysis. Mrs. P.M. is a widow and lives with her elderly, incapacitated mother. The problem was, who would look after her and stay with her while she was dialyzed?

Fortunately, she has a daughter and a daughter-in-law, both with young families, who arranged to learn together and to take turns to help with Mrs. P.M.'s dialysis. The three cooperated well and learned quickly, so that after 10 weeks of



Mr. L. on dialysis in his own home. Everything needed for his comfort is at hand: he can sit and read, watch television, or sleep, safe in the knowledge that his alarm system will warn him of any irregularity.

Home Dialysis Equipment. This complete unit shows: 1. the heparin pump; 2. the dialyzer; 3. the flow restrainer; 4. the venous pressure line; and 5. the control unit with alarms.



traveling to and from Montreal twice a week, they were ready to go home.

Mrs. P.M. has now been home for 16 months; her blood chemistry is well-controlled by twice-weekly dialysis, she works full time, and has only returned to the unit on one occasion for dialysis.

Program successful

Home dialysis has proven very successful; the rate of infection is virtually nil, and problems over dialysis and equipment are few. The patient likes to be at home with his family, and, with a little intelligent organization, there need be only a small amount of disruption to the family routine. The patient on home dialysis does not have to worry about traveling to and from the hospital, and persons who would otherwise be too far from a dialysis unit to make hospital dialysis practical, can benefit.

Each month a "Newsletter" is sent to each patient with news and views from the medical and nursing staff and from the patients themselves. A favorite inclusion is salt-free recipes and a list of restaurants that serve salt-free meals.

One major problem, the cost, is being adequately met by some provincial governments; however, patients in other provinces have to rely on insurance, kindly firms, or wealthy relatives.

The cost of the basic equipment is:

Tank, pump & control box	$ 837.
Kiil dialyzer and stand	$ 905.
Heparin pump	$ 160.
Centrifuge	$ 86.
Total	$1,988.

The annual cost of thrice-weekly dialysis in the home is $3,500, after an initial cost of $2,500 for the basic equipment and alterations in the home. This is approximately one-quarter of the cost for each patient on dialysis in hospital.

At present, the dialysis unit at The Montreal General Hospital is the only unit in Eastern Canada that has patients receiving dialysis in the home. Similar programs are being started in Ottawa and Hamilton, Ontario, and in Vancouver, British Columbia; there are, of course, many hospitals that offer hemodialysis in the hospital.

Home dialysis makes it possible to give a new life to many more people than would otherwise be possible. We believe it is a practice that will increase rapidly in the near future. □

idea exchange

Communal Dining



Patients in nursing homes or homes for the aged frequently are apathetic about feeding themselves, and this apathy follows a set pattern. The indifference is more pronounced where the resident eats in his own bed, or alone at the bedside from a tray, without social interaction. He begins to toy with his food, eating less and less. When this persists, the nurse often gives help to provide a sufficient caloric intake. This, of course, does not improve the situation; the resident lacks the appetite, or is too weak, or enjoys the attention of the nurse too much to make the effort. He now enters in the downward spiral toward total dependency – that of being fed.

Since this indifference to eating often takes so much time, the nurse may resort to minced or pureed food. The resident has now reached a low ebb with the loss of dignity and worth. This usually completes the picture of total regression.

The road back to self-feeding is a difficult one, because pride and self-esteem must first be restored. The individual must be handled delicately, and with tact. A habit has to be broken.

The nurse begins by setting goals that can be reached, so as not to discourage an already indifferent person. Once the patient starts to accept the change in routine, he can be introduced to fellow diners and the dining room.

In spite of careful introduction, some residents are confused when they face the change, but they do adjust under the guidance of a helpful nurse. First attempts at feeding can be just as painful as they were long ago, but just as rewarding. Residents slowly graduate to a higher level, step by step. Plates are introduced with minced, then solid food; later the patient relearns how to manage knife and fork. Patience is required during the relearning stage.

The indifference pertains to other activities of daily living as well as eating. Eating cannot be divorced from these other activities because the whole picture has to improve. One of our residents was extremely reluctant to leave her room and refused to eat in the dining room. She was encouraged tactfully and patiently to try crafts. One day, six months later, after a busy afternoon of work and socializing, she demanded her right to eat at the table with the rest of the ladies.

If possible, the dining area should be subdivided into two or three smaller areas. This can be achieved with shoulder-high, moveable screens or plant dividers, or even just larger separations between tables. The reason: eating habits or the ability to manage utensils varies among patients; some patients are ill at ease in the presence of less able eaters.

It is a good idea to precede mealtimes with brief entertainments, to set the mood for sociability. At our hospital, grace is said by a resident and a short lesson is read. Low background music also improves the atmosphere.

Mealtime should be a special event. Tables must be attractively set, and a gracious dining room atmosphere should prevail. Much is gained by this step.

Results speak for themselves. In August 1967, 30 percent of our patients had to be fed by staff; in May 1968, only 14 percent needed to be fed; and in July 1968, only 11 percent. – Mrs. Vera McIver, Director of Hospital Services, St. Mary's Priory Hospital, Victoria, B.C. □

books

Countdown 1968. 151 pages. Ottawa, Canadian Nurses' Association, 1968.
Reviewed by Mary L. Richmond, Director of Nursing, The Vancouver General Hospital, Vancouver, B.C.

"What happens to all the statistical data I send the CNA each year about myself and our agency? Does anyone ever do anything with them? "

Yes! Their collection and orderly arrangement in *Countdown 1968* makes very interesting and provocative reading. It also provides a base for trend prediction, which is fundamental to both personal and agency planning.

How does your turnover rate compare with that of other places in your province? How does your province compare with the rest of Canada? Is there a way of estimating turnover rates that makes it possible to compare one setting with another? You will find answers to some of these questions in *Countdown 1968.*

How does the percentage increase in auxiliary personnel compare with the increase in registered nurses?

Compare your percentage of head nurses having baccalaureate degrees with that of other hospitals your size.

Also find out the answers to these questions: Are we, as a country, progressing far toward improving the educational standing of our service and teaching personnel? How many of our nursing supervisors have academic degrees? How do our salaries from province to province compare among various categories of nurses? Is there a place for male nurses in Canada? How many are there?

Countdown 1968 is the sequel to *Countdown 1967* and is a publication of the Canadian Nurses' Association. It is a compilation of a great deal of statistical information about nursing personnel in Canada. Its 151 pages contain 133 tables with well-worded headings; the contents and text are evidence of the cooperation between individuals and data-gathering agencies.

There is little text, but a brief background note and an identification of highlights and trends emerging from the tables introduce each section.

While the tables have obviously been prepared by a statistician, one need not be a statistician to understand and appreciate them, or to have one's curiosity aroused. The explicit titles and headings of the tables, plus the brief notes in the text, make the data meaningful to both the nurse who is not a statistician and the non-nurse. The background material explains our "universe of professional discourse." This explanation is essential both to the non-nurse and the nurse not particularly familiar with the vocabulary or the peculiarities of the nursing world. For example, there is an explanation of postbasic programs in nursing and of educational programs for nursing assistants.

The publication serves both as a source book for locating specific data and as thought-provoking reading – preferably taken in not-too-large doses.

Countdown 1968 provides essential data for those engaged in long-range planning. For those who like to "wonder why," it opens up vast areas of further inquiry.

The real value of this publication will derive from what we as a profession and we as a nation do with it!

Read, wonder, and perhaps, with me, thank our national office for providing one more tool in helping to construct health services for Canadians.

Textbook for Midwives, 6th ed., by Margaret F. Myles. 792 pages. Edinburgh & London, E. & S. Livingstone Ltd., 1968. Canadian Agent: Macmillan Co. of Canada, Toronto.
Reviewed by Molly Evans, Clinical Instructor in Obstetrics, Royal Columbian Hospital, New Westminster, B.C.

The 6th edition of Miss Myles' textbook of midwifery is testimony to her profound interest and sound knowledge of the art and practice of all facets of midwifery, and to her ability to teach.

This fascinating subject is presented under eight headings and approached from basic female anatomy, the physiology of the reproductive cycle, the development of the fertilized ovum, the placenta, and fetus.

The major sections of pregnancy, labor, and the puerperium are subdivided from normal physiological changes to the clinical application of such change for the protection of the mother and baby. The role of the midwife in caring for the family is carefully elucidated; she practices only within the law and limit of the Midwives Act. Therefore the normal section of each subject is immediately followed by deviations from the normal, and the early recognition of such deviations is emphasized.

The major asset of this text is the presentation of the subject matter; it is clear, concise, in logical sequence, and, consequently, provides easy reference.

This new edition contains up-to-date information on the "high risk" group of mother and babies and the Saling method of amnioscopy and fetal blood sampling along with other research projects that have been perfected in the past two years.

A suggested outline of an educational program for parents in preparation for parenthood is interesting. The first discussion group is to be held at six to eight weeks gestation, subsequently at 20 weeks, and then each two weeks until 36 weeks gestation. Actual techniques of preparation for labor are astutely summarized as a wise precaution against emphasis of "method" as opposed to education as a basis for sound preparation.

Illustrations and diagrams are excellent. Some photographs unfortunately are sadly out of date and do little to enhance the image of the midwife.

Canadian nurses working on the obstetrical team would find the book an excellent, if selective, reference.

Introduction to Human Embryology by James Blake Thomas, Ph.D. 348 pages. Philadelphia, Lea & Febiger, 1968. Canadian agent: Macmillan Co. of Canada Ltd., Toronto.
Reviewed by Carol L. McWilliam, Instructor, The University of New Brunswick, Fredericton, N.B.

In this book, the author has met his objective of "describing human prenatal development within a broad frame of reference." Using this as a criterion, the book might be considered a success.

(Continued on page 48)

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By Claire Brackman Keane, R.N., B.S., former Director, Athens (Ga.) General Hospital School of Practical Nursing.

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books

(Continued from page 46)

Dispensing with the classical approach to the subject, he has included material on the psychological impact of pregnancy on the family, signs and symptoms of pregnancy, labor and delivery, physiological adjustment of the fetus to the extra-uterine world, and the puerperium. Reproduction, normal embryological and fetal development, and abnormal development are all discussed more extensively.

The writing style is clear and the content well organized. Avoiding the systemic approach, which tends to ignore the fact that no organ or system develops independently, the author has divided his text into chapters outlining weekly, and, later, monthly, development. These he has consistently subdivided into sections on external body form, body systems, placenta and fetal membranes, and maternal signs and symptoms. However, poor placement of illustrations in sections throughout the text makes it difficult to follow these in conjunction with descriptive content.

This book would best be used as a reference text by nurse clinicians and obstetric instructors who are already familiar enough with the subject to dispense with illustrative material. Its use as a text for students of nursing will be limited unless the illustrations are rearranged in future editions.

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Psychiatric Nursing, 8th ed., by Marguerite Lucy Manfreda, R.N., M.A. 474 pages. Philadelphia, F.A. Davis Company, 1968. Canadian agent: The Ryerson Press, Toronto.
Reviewed by Agnes Herd, Associate Director of Nursing Education, Moose Jaw Union Hospital, Moose Jaw, Sask.

The 8th edition of this text continues to reflect the author's belief that psychiatric nursing is both a specialty and an integral part of all nursing. The primary emphasis of the text is upon medical and nursing aspects in a psychiatric treatment center.

All the chapters have been updated to include modern developments and trends in social psychiatry. The chapters on somatic therapies and therapy with tranquilizing and antidepressant drugs have been completely rewritten. The chapters on group nursing and social, recreational, art, and music therapies would be helpful to persons who are learning as well as those who are interested in and responsible for expanding a social activity program.

Chapters 13 through 18 deal with basic fundamentals of nursing. This topic is discussed more fully in any good fundamentals of nursing text.

Fifteen of the 43 chapters are devoted to behavior and nursing care of patients. The title of each of these chapters combines classification terminology with the most outstanding characteristic of the individual disorder discussed, making it possible to locate readily subject matter in this area of the text.

The last two chapters provide a brief summary of the prevailing attitudes toward mental illness throughout the history of civilization and the emergence in America of the current emphasis on preventive community psychiatry.

The references at the end of each chapter are current and well-chosen, and many of them are readily available.

The writing style tends to be didactic and somewhat dogmatic. For this reason, students in a basic nursing program might not find this comprehensive text either interesting or stimulating.

Determinants of The Nurse-Patient Relationship by Gertrud Ujhely. 271 pages. New York, Springer Publishing Company, Inc., 1968.
Reviewed by Thelma MacLeod, Supervisor, King's County Memorial Hospital, Montague, P.E.I.

This book deals with the many variables that affect the nurse-patient relationship. It is easily read and comprehended by the practicing nurse. The beginning nurse-student may find it bewildering when reading it for the first time, but will probably be able to refer to it mentally when she encounters one of the situations outlined.

Part 1, "What the Nurse Brings to the Relationship," effectively explores the many facets of an individual's personali-

books

ty, values, professional and personal expectations and attitudes, and the conflicts encountered when theory meets reality in the health field.

Part 2, "The Context Within Which the Relationship Takes Place," is at times heavy reading, but the author's examples of actual cases help to keep the reader in touch with the situation.

In the chapter entitled "Hospital and Long-Term Institution," the patient's problems and the nurse's problems are considered. The nurse is remonstrated not to feel too defeated or resigned when she realizes that she cannot solve all patients' problems. Some patients could neither function without their problems nor do they wish to have them solved.

The chapter entitled "The Patient's Home" affords insight into what the visiting nurse might encounter in a home.

Part 3, "What the Patient Brings to the Relationship," emphasizes that the patient, whether unconcious, blind, shy, cantankerous, or overly pliable, should be treated with the same regard for dignity, compassion, and respect that one would expect for oneself.

I thoroughly enjoyed reading this book and would advocate its inclusion in nursing schools and hospital libraries as an introduction for beginners to the social aspects of nursing and as a compulsory review for working nurses who find that their lamps are dimming and their great expectations are somewhat jaded.

The Medical Secretary as a Word Technician by Anne Hadley. 260 pages. Toronto, J.B. Lippincott Company, 1968.

Reviewed by Helen O'Connor, Medical Secretary Course, Algonquin College of Applied Arts and Technology, School of Business, Ottawa, Canada.

The author has approached the subject of medical terminology for the medical secretary in a most unusual fashion. She has departed from the customary review of the systems and the related medical terminology. Her book is based on a series of actual case histories – consultations, physical examinations, and surgical procedures.

Phonetic spelling has been used throughout as an aid to pronunciation. This could have been more effective if it had been used only in a vocabulary preview, or, as in the case of this book, in a breakdown after each lesson, and not included as part of each case history.

Simple, precise, nontechnical drawings that illustrate the various explanations are interesting and informative.

Definitions generally are simple, but much time has been spent giving a breakdown of the origin of the various terms: e.g., "anesthesia = no or not + feeling; cyanosis: blue, a state of being (looking) blue – finger nails or lips can be blue." This appears to be an over-simplification and might have been replaced by a simple, straightforward definition of the word.

Although there may have been a plan for presentation of the material in its present form, it is difficult to follow. The subject has not been approached through an explanation of a system of the body nor on the basis of medical specialty, but for the most part is a series of unrelated case histories.

The author says that the book was written to train the medical secretary. However, this book seems to assume that the girl being trained for this career already has a basic knowledge of anatomy and medical terminology. It might be of value as a reference text for persons employed as medical secretaries, who possess a knowledge of medical terms.



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BOOKS AND DOCUMENTS

1. *Album-annuaire, 1968.* Grenoble, France, Maisons d'enfants et d'alolescents de France, 1968. 309p.

2. *Atlas international Larousse politique et économique.* Paris, Librairie Larousse, 1965. 45p. R

3. *Australasian hospital, directory, and nurses' year book. 1968/1969,* Sydney, N.S.W. Nurses' Association, 1968. 192p. R

4. *Cadet nurse of the White Cross* by Marguerite Lees. London, Max Parrish, c.1962. 143p.

5. *Canadian Almanac & directory for 1969.* Vancouver, Copp Clark, 1969. 881p. R

6. *Canadian Nurses' Association Biennial Convention, July 8-12, 1968.* Saskatoon, Sask. Special interest sessions, Ottawa, Canadian Nurses' Association, 1968. 140p.

7. *Code for safety to life from fire in buildings and structures.* Twentieth edition. Boston, National Fire Protection Association, 1966. 208p.

8. *Collective bargaining: the power to destroy; new and better ways to industrial peace* by Merryle Stanley Rukeyser. New York, Delacorte, c.1968. 220p.

9. *Compendium des produits et specialités pharmaceutiques (Canada) 1968.* Toronto, L'Association Pharmaceutique canadienne, 1968. 580p. R

10. *Countdown; Canadian nursing statistics 1968.* Ottawa, Canadian Nurses' Association, 1968. 151p.

11. *Dictionnaire de statistique* par E. Morice avec la collaboration de M. Bertrand. Paris, Dunod, c1967. 196p.

12. *Extending the boundaries of nursing education; the preparation and role of the nurse scientist: papers presented at the second conference of the Council of Baccalaureate and Higher Degree Programs,* Cleveland, Ohio, March 27-29, 1968. New York, National League for Nursing. Dept. of Baccalaureate and Higher Degree Programs, 1968. 64p.

13. *Health services administration: policy cases and the case method,* edited by Roy Penchansky. Cambridge, Harvard Univ., 1968. 460p.

14. *Hospital libraries and work with the disabled,* edited by Mona E. Going. London, Library Association, 1963. 198p.

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16. *The human side of enterprise* by Douglas McGregor. New York, McGraw-Hill, 1960. 246p.

17. *Hygiène, santé et bien-être* par Françoise Savard. Rev.ed. Montréal, Editions du Renouveau pédagogique, c1968. 255p.

18. *RN hospital school survey, 1968.* Oradell, N.J., RN magazine, 1968. 46p.

19. *Report of the Kellogg Foundation, 1968.* Battle Creek, Mich., 1968. 128p.

20. *Improving employee-management communication in hospitals;* a special study in management practices and problems. New York, United Hospital Fund of New York, 1965.1v. (various paging).

21. *Marital breakdown* by Jack Dominian. Middlesex, England, Penguin Books, c1968. 172p.

22. *Memoirs of a bird in a gilded cage* by Judy LaMarsh. Toronto, McClelland and Stewart, c1968. 367p.

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24. *Nurse career – pattern study pt. 1 practical nursing programs* by Barbara L. Tate and Lucille Knopf. New York, National League for Nursing, 1968. 182p.

25. *Nurse's guide to common surgical operations* by R. Gordon Cooke. London, Faber, 1967. 71p.

26. *Principles of hospital planning,* edited by Robert Jefford, London, Pitman Medical, 1967. 83p.

27. *Répertoire de vedettes – matière.* Québec, P.Q., Université Laval. Bibliothèque, 1968. 1458p.

28. *Secourisme de la Croix Rouge.* 1st ed. Toronto, La Société Canadienne de la Croix-Rouge, 1968. 91p.

29. *Select bibliography in higher education.* A quarterly list. July to September 1968, October to December 1968, Ottawa, Association of Universities and Colleges of Canada, 1968. 2v.

30. *Statesman's year-book;* statistical and historical annual of the states of the world for the year, 1968-69. London, MacMillian, 1968. 1727p. R

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PAMPHLETS

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33. *Community health care in a technically advanced society* by Thomas McKeown. New York, American Nurses' Association, c1968. 20p.

34. *Continuing education for nursing;* tools and techniques. New York, American Nurses' Association, 1968. 32p.

35. *Extending campus resources;* guide to using and selecting clinical facilities for health technology programs. Washington, American Association of Junior Colleges, 1968. 28p.

36. *Guide to the syllabus of subjects for examination for the certificate of general nursing.* London, General Nursing Council for England and Wales, London, 1962. 14p.

37. *Guidelines for establishment of an employee grievance procedure.* Chicago, American Hospital Association, c1968. 8p.

38. *Influencing nursing practice in changing hospital settings* by Anna T. Baziak. New York, American Nurses' Association, 1968. 9p.

39. *Knock before entering personal space bubbles* by Myra E. Levine. New York, American Nurses' Association, 1968. 2pts in 1. (Excerpted from Bulletin Chart vol. 65, no.3, March 1968).

40. *Nursing and long-term care/the research program of the American Nurses' Foundation* by Eleanor C. Lambertsen. New York, American Nurses' Association, c1968. 16p.

41. *Paid vacations and how they are granted* by Pascal Ingenito. Ottawa, 1968. 26p.

42. *Proposal for a uniform plan for hospital statistics* by Florence Nightingale, London, Her Majesty's Stationery Office, 1860. p.63-71. (Reprint from Programme of the Fourth Session of the International Statistical Congress to be held in London on July 16, 1860.) R

43. *Report submitted to the Minister of Health, 1967/68.* London, General Nursing Council for England and Wales, 1968. 54p.

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45. *Syllabus of subjects for examination for the certificate of general nursing.* London, General Nursing Council for England & Wales. London, 1962, reprinted 1967. 12p.

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47. Bureau of Statistics. *Annual report of notifiable diseases.* Ottawa, Queen's Printer,

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1968. 43 pages.

48. Bureau of Statistics. Labour Division. *Benefit periods established and terminated under the unemployment insurance act.* Report, 1967. Ottawa, Queen's Printer, 1968. 51p.

49. ———. *Estimates of families in Canada,* 1967. Ottawa, Queen's Printer, 1968.

50. ———. *Hospital statistics;* v.4 balance sheets, 1966. Ottawa, Queen's Printer, 1968. 51p.

51. ———. *Hospital statistics;* v.6 hospital expenditures, 1966. Ottawa, Queen's Printer, 1968. 89p.

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53. ———. *Mental health statistics, 1965;* v.2 patients in institutions. Ottawa, Queen's Printer, November 1968. 527p.

54. ———. *Survey of vocational education and training,* 1965-1966. Ottawa, Queen's Printer, 1968. 88p.

55. Dept. of Labour. *Women in the public service;* their utilization and employment by Stanislaw Judek. Ottawa, Queen's Printer, 1968. 142p.

56. Dept. of National Health and Welfare. *Characteristics of the population covered under the guaranteed income supplement of the old age security program Canada, 1967.* Ottawa, 1968. 14p. (Research and Statistics memo).

57. ———. *Reference reading list on nutrition an annotated bibliography on nutrition, food and related subjects.* Ottawa, 1968. 64p.

58. ———. *Report on cigarette smoking and health;* presented to the Health, Welfare and Social Affairs Committee of the House of Commons by the Honourable John Munroe, Minister, Department of National Health and Welfare on December 19, 1968. 1v. (various paging).

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59. Office du Film. *Catalogue permanent des films* distribués par l'office du film du Québec, 1968. 1v. (loose-leaf).

U.S.A.

60. Dept. of Labor. *Report of a Consultation on Working Women and Day Care Needs, Washington, June 1, 1967.* Washington, 1968. 86p.

61. U.S. National Center for Health Statistics. *Migration, vital and health statistics; a report of the United States National Committee on Vital and Health Statistics.* Washington, U.S. Public Health Service, 1968. 17p.

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63. ———. *Selected impairments.* Washington, U.S. Public Health Service, 1968. 78 p.

64. ———. *Variations in birth weight.* Washington, U.S. Public Health Service, 1968. 35p.

STUDIES DEPOSITED IN CNA REPOSITORY COLLECTION

65. *Approach to the phases of nurse-patient relationships* by Marjorie A. Wallington.

66. *Census of nursing personnel employed for public health work in Ontario by position and highest academic qualification on November 30, 1966.* Toronto, Dept. of Health, 1968. 57p. (principal investigator: Isabel Black). R

67. *Etude documentaire des besoins de la mère et des membres de la famille durant le cycle maternel* par Sister Rachel Rousseau. Montréal, 1968. 108p. Thesis (M.Nurs.) – Montréal. R

68. *Non-professional male worker as a part of the patient care team* by S. Arthur H. Craig. Toronto, 1967. Ann Arbor, University Microfilms 1968. 62p. Thesis – Toronto. R

69. *Study of the routine taking of temperature, pulse and respirations on hospitalized patients* by Pamela E. Poole. Ottawa, Dept. of National Health and Welfare, 1968. 21p. R

70. *Study to compare the nursing care given by professionally and technically prepared nurses on a medical unit* by Betty Louise Sellers. Washington, 1968. 59p. Thesis (M.N.) – Washington. R

71. *Survey of graduates of the University of Toronto baccalaureate course in nursing* by Nora I. Parker. Toronto, School of Nursing, University of Toronto, 1968. 66p. R

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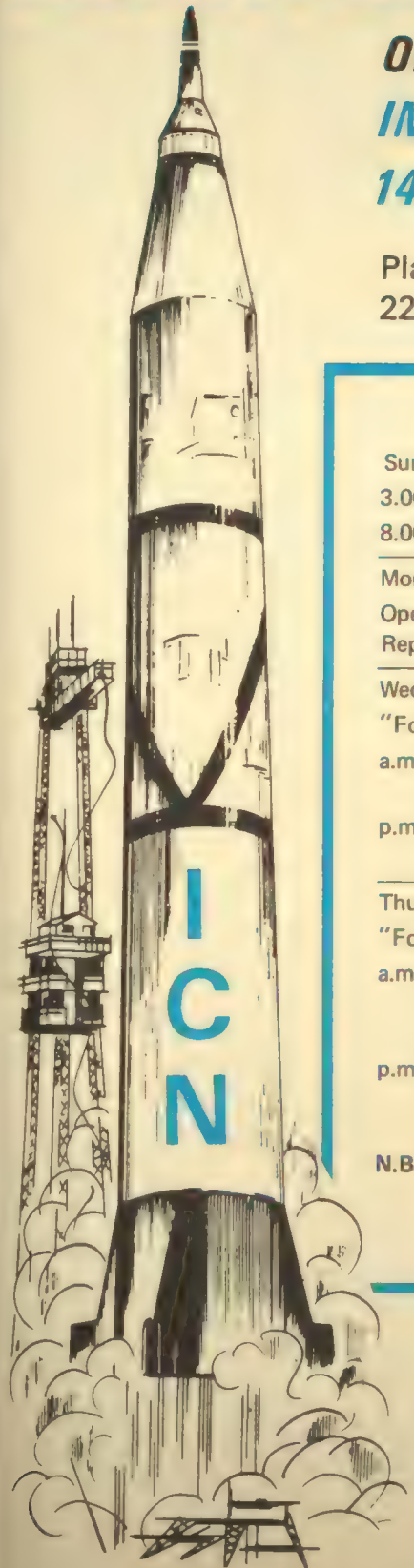
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8.00 p.m. Opening Ceremony

Monday and Tuesday, 23 and 24 June
Open meeting of Council of National Representatives (CNR)

Wednesday, 25 June
"Focus on the Future"
a.m. Plenary session —
Forecasting the Future
p.m. Plenary session —
Implications of Change

Thursday, 26 June
"Focus on the Future"
a.m. Plenary session —
Education for Today and Tomorrow. Basic Programs
p.m. Plenary session —
Education for Today and Tomorrow. Post Basic and Postgraduate Programs
5.00 p.m. Voting for ICN Officers by CNR
8.00 p.m. Students' Congress

Friday, 27 June
"Focus on the Future"
a.m. Plenary session —
Security for Tomorrow
p.m. Plenary session —
Leadership in Action
8.00 p.m. Closing Ceremony
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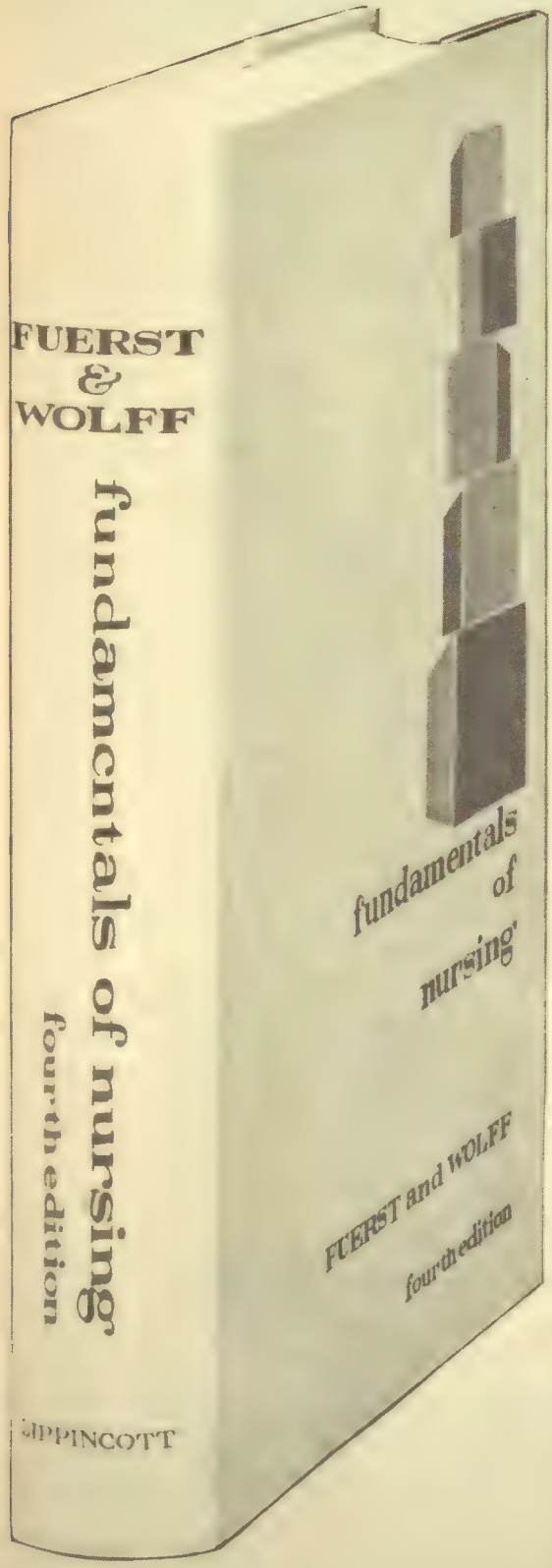
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Message From

The Executive Director

The most significant happening of the century in diploma nursing education is taking place today: of the 209 diploma schools of nursing programs, 26 are now in educational institutions within the post-secondary educational system. Last year 1,901 students were admitted to these programs, representing 19.3 percent, or about one-fifth, of the total admissions. Five years ago there were none. Ten years ago, though the literature of three decades documented the need, the dawn of change was not yet on the horizon.

How and why did it happen? This happening is the saga of a few committed to the belief that only through improved nursing education could nurses be prepared to function in health care systems of foreseeable complexity. These innovators knew that nursing preparation should embrace a broad, general educational experience. They knew that experience should develop creativity and adaptability for practice in an expanding spectrum of health services. They knew that their goal was a difficult one that would often be obstructed by the champions of specializations.

This movement has begun in five provinces. Others will follow, finding it is difficult to justify a system of nursing education suited to an era already past, or rapidly passing. Many hurdles remain to be taken by those with the prowess to clear them and to join the vanguard of reform in diploma nursing education.

The graduates of these new diploma programs, working in concert with the graduates of university schools of nursing, will use their knowledge and skills to contribute to a higher standard of nursing care on the health teams of Canada. — **Helen K. Mussallem.**

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Error

I would like to bring to your attention a mistake that was made in the February 1969 issue of *The Canadian Nurse.* In the article "Clinical Laboratory Procedures," page 46, I found the following statement:

> CO_2 is "increased in alkolis (respiratory obstruction, vomiting, ingestion of bicarbonate); decreased in acidosis (diabetes, over breathing, etc.)."

Respiratory obstruction should be an example for *acidosis* of respiratory origin where the CO_2 is increased. On the other hand, over breathing (hyperventilation) will bring about *alkalosis* of respiratory origin where the CO_2 is decreased. Therefore I suggest that the above quoted statement should be corrected and the reference concerning acidosis and alkalosis should be divided since the CO_2 behaves differently in respiratory and metabolic acidosis and alkalosis. In fact the total CO_2 content in the plasma increases in the case of respiratory acidosis and metabolic alkalosis and decreases in the case of respiratory alkalosis and metabolic acidosis. – Zoltan Lipcsey, RITT(C), Charge Inhalation Therapist, Ottawa General Hospital.

Mr. Lipcsey is correct. See "erratum" at bottom of this page. – Editor.

Caps and uniforms

In her letter to the editor in the December 1968 issue, Dr. Black gives the impression that a nurse must wear a uniform to be a nurse. We disagree.

What is a nurse? Is a nurse a uniform? What is the purpose of a uniform? We feel that a nurse should choose her clothing according to her working situation.

Does a uniform give a nurse a sense of authority? Is this "sense of authority" a feature of a good patient-nurse relationship? We think not. We think the basis of a good nurse-patient relationship is empathy, not authority.

By wearing a white starched uniform, the nurse does not necessarily assure the patient of the necessary standards of hospital cleanliness. By a poor technique she may have contaminated her white uniform with a multitude of invisible microorganisms.

We do not agree that "a uniform can transfigure a woman who looks ordinary or even dowdy in civilian clothes into a handsome, imposing person." First, a woman does not become "handsome" just by wearing a white uniform. Second, we feel that an "imposing" nurse is an unapproachable nurse.

Next, we do not agree that "nurses [are] discarding their uniform because they fear they will be degraded by current methods of improving working conditions and salaries, i.e., threats of strikes and demands for arbitration, which the newspapers so delight in reporting." Nor do we believe that the intelligent youth of today choose a profession by its uniform. If they do, they do not know what a profession is. We do not see the relationship between the ritual of a "thrilling capping ceremony" and "tangible appreciation for endeavors."

Dr. Black was unable to identify a nurse in the nursing administration area because no one wore a uniform. We believe that knowledge and skill identify a nurse – not a uniform. – Wilda Michaluk, Eileen Ateah, Dianne Coutts, Sharon Bateman, RNs, Winnipeg, Man.

British Health Service

I was particularly interested, as an English hospital administrator now working at The Hospital For Sick Children in Toronto, to read the book review of *A Unified Health Service* in the February edition of your magazine.

Your reviewer fell into a common trap when considering the British National Health Service, of failing to perceive anything beyond an apparently impossibly complex bureaucratic administrative organization. Admittedly, this can be much improved, and it is to be hoped that some structural change will follow the report of a recent government paper. The failure is in the absence of any acknowledgement of the comprehensiveness of the medical and nursing care available to patients. – D.J. Knowles, Toronto, Ont.

Erratum

An error was made in the "Clinical Laboratory Procedures" article in the February 1969 issue. On page 46, the information given under the heading "clinical significance" for carbon dioxide should read:

> "CO_2 is increased in respiratory acidosis (respiratory obstruction) and in metabolic alkalosis (ingestion of bicarbonate, vomiting); decreased in respiratory alkalosis (over breathing) and in metabolic acidosis (diabetes)."

Two-year program

I am writing about the article in the February issue concerning the two-year program versus the three-year program.

I was disappointed to see that you failed to mention the two-year programs that are in progress in Ontario. I am thinking of the program at the Nightingale School of Nursing in Toronto, introduced in 1960.

The comparison in this article, which involved the Grey Nuns' School, did not make clear that both programs were in progress at the same hospital and that, in fact, the school was changing from a three-year to a two-year program. I felt this article was trying hard to find fault with the two-year program.

I am a graduate of the Nightingale School of Nursing's two-year program and in no way feel less capable than my three-year counterparts. I received a wide variety of experience, with a good academic background. We learned to adapt quickly to new settings since we went to several different hospitals during our training. We also learned that when we encountered new nursing situations there were always books to consult. You can learn anything, as long as you know the principle behind it.

We have graduates in every field of nursing. Most of them are doing well. It is true that some graduates are not up to par – but we are dealing with human beings.

I am sorry you allowed such a narrow-minded article to be published. Our magazine should be used to enlighten nurses. – Ann Gregg, R.N., Winnipeg, Man.

We, the faculty of St. Joseph's School of Nursing, Toronto, strongly question the conclusions set forth in the article "Two-Year Versus Three-Year Programs" (February 1969). In many instances the conclusions set forth by the authors are either not substantiated by factual evidence or appear to be in direct opposition to the evidence.

When rated in the simulated nursing situations, the differences in favor of the control students were significant in only *one out of three* situations; this does not warrant the authors' conclusions (p.64) that the control students "showed more of the expected behaviors and performed them more quickly in a simulated nursing situation."

In the State Board examinations, only

the difference in child nursing was significant in favor of the control students. In the school of nursing examinations, only the obstetric and psychiatric nursing results were significant in favor of the control students; of these, only the obstetric nursing results appear to be significant, since all control students did not write the psychiatric nursing examination. In the National League of Nursing examinations, none of the differences in results were statistically significant. Yet the authors state, "In the three written examinations... the control students did better than the experimental students."

When an instrument is reliable, different raters should be able to use the instrument with the same subjects and obtain similar results. Since, in this study, the outside raters did not agree, we question the reliability of both the instrument and the raters.

We question the validity of results that are based on different numbers of participants in the study, e.g. "... some of the comparisons between the experimental and the control group are made on only 24 pairs, rather than 40 pairs, of students" (p.63).

The lists of critical incidents by which the nurses were evaluated at 3 and 12 months following graduation were not identical in length; we therefore query the validity of this, as well as the criteria by which it was determined to eliminate certain critical incidents.

Our concern over this report is heightened by the fact that St. Joseph's School of Nursing has a two-year program and that this report does not present an accurate picture of the differences between students in two- and three-year programs.

We question the authors' statements that this study was carried out in a "systematic and objective" manner. Accurate analyses of the data do not provide the "conclusive evidence" claimed by the authors.

Because this report was published in *The Canadian Nurse,* many nurses will read the article and, without delving into it too deeply, will assume this was a valid study; in spite of the authors' cautions, decisions will be made about two-year programs on the basis of the results of this study. Therefore, we strongly urge *The Canadian Nurse* to peruse research articles with greater care in the future, with a view to publishing only accurate interpretations of data. – (Mrs.) Olga E. Chapchuk, R.N., B.Sc.N., First Year Teacher.

It was with pleasure that I began to read the report of the study of graduates of the two- and three-year nursing programs at Regina Grey Nuns' Hospital (February, 1969). By the time I had finished reading it, however, my pleasure had turned to disappointment and dismay.

In the first place, in spite of the authors' confidence in the power of statistical procedures to offset the unreliability of small samples, 24 pairs of subjects seems a very small number from which to obtain "conclusive evidence." That the two outside raters differed from one another "to quite an extent" makes one wonder how much error variance, attributable to individual differences or idiosyncrasies between raters, was introduced. This, coupled with the extremely difficult task of providing similar ward experience for all subjects, certainly made testing conditions far from ideal.

It was surprising to note that the researchers used a simulated nursing situation as a criterion of effective nursing; the validity of such an artificial situation could well be questioned. Hence, the methodological faults of this study may be at least as serious as some of those cited in the authors' review of previous evaluative research on two-year programs.

The most glaring weakness of the report is the manner in which the authors interpreted their findings. In reporting the results of ward performance ratings, the authors noted that the difference in favor of control students was significant (i.e., greater than that which could have occurred by chance) for *one* of the raters. Does this mean that the difference for the other rater was non-significant (i.e. that there was *no real difference)*? If such is the case, the evidence is hardly *conclusive.* That there was no difference between groups on intermediate tasks in the simulated nursing situations casts doubt on the overall superiority of three-year students. One could query the importance of speed in this setting.

The authors reported *real* (significant) differences between groups on only *one* State Board Examination and *only two* school of nursing examinations. Is this what the authors call *conclusive evidence* of the superiority of three-year students?

The report states that three months after graduation, there were no significant differences between two- and three-year graduates on *seven* out of *ten* aspects of nursing performance; again, such findings are hardly conclusive of control group superiority. Although the details on the 12-month evaluations are obscure, the authors claim significant differences in favor of three-year graduates.

It is amazing that the researchers chose to label non-statistical differences "conclusive evidence" of superiority of one group over another. Even more amazing is that *The Canadian Nurse* chose to print a report which is so misleading to members of the profession and the public, who, in spite of the authors' pleas for caution, will make decisions on the basis of findings of this report. Surely your subscribers deserve better treatment than this! – M. Josephine Flaherty, Reg.N., Ph.D., Toronto.

Dr. Costello replies

The number of subjects (24 in each group) is not a small one, particularly in view of the fact that these are matched subjects. What is always far more dangerous is the obtaining of small significant differences by the use of very large samples. Dr. Flaherty and some of your readers may be interested in a book by P.O. Davidson and myself, which will appear in May, entitled "N = 1." Even samples of this size can permit one to draw conclusions with considerable confidence.

Dr. Flaherty tries to make a lot out of the fact that not all the differences between the groups were significant. The important thing, however, is that in just about every comparison the control students did better than the experimental students. Of course, it is because of the great inter-subject variability that they did not all come out significant, but the very consistency of the direction of the differences enables us to have considerable confidence in those findings that are significant. To accept the null hypothesis of no real difference between the groups in the case of these data would be quite unwarranted.

Of course ward experience was not identical for all subjects; however, there is no reason to think that there is any systematic difference in the ward experience of the experimental and control students so that it cannot be used to account for our findings. All that one can say is, despite differences between the raters, the findings consistently showed the control student to be better. Simulated situations have generally been of value for testing model ships, model rockets, model astronauts, and model soldiers; I see no reason why they should not be of value to assess model nurses.

Dr. Flaherty says there was no difference between the groups on intermediate tasks in the simulated nursing situation. Our article reports that there was a significant difference between the groups on the intermediate tasks. She suggests that one could query the importance of speed in this setting. At the age of 38 I have been blessed with good health and have never been hospitalized. When I am, I hope the nurses attending me will not be the lethargic type.

To suggest that the methodological faults of this study may be at least as serious as those reviewed is quite ridiculous.

Finally, we have not suggested that the nonsignificant differences provide conclusive evidence of differences. We have said, to repeat, that the significant differences among findings that go consistently in one direction can be accepted with a

considerable degree of confidence. I do not want to be ungentlemanly, but I really do feel that it is not so much that the subscriber to *The Canadian Nurse* deserves better treatment, but that *The Canadian Nurse* deserves more careful reading. – C.G. Costello, Ph.D., Professor, Department of Psychology, The University of Calgary.

Subscriptions

This is a good time, as postal rates increase, to end the strange phenomenon of a professional group being forced to subscribe to a magazine.

I am strongly against paying for *The Canadian Nurse*. I do not read it, nor do my two roommates. We are all nurses who are forced to receive *three* journals in one apartment! We live in a large apartment house – and the day the journal arrives, you can find half a dozen copies of the current issue piled up near the incinerator.

Nurses in Nova Scotia do not receive the same rate of salary as do nurses in Ontario, so any increase in subscription rates dreamed up by the board of directors of the CNA would be a burden to us.

We receive other medical journals and have resource to our hospital libraries, where all new trends in medicine are available. Let us not force nurses to receive periodicals they do not want. Others will subscribe if they choose to do so. – E. Sutherland, R.N., Halifax, N.S.

The subscription-through-fees plan was not decided by the Canadian Nurses' Association. The membership of each provincial nursing association voted in favor of this plan in the 1950s. Actually, it is not a "strange phenomenon." Most professional associations, including the Canadian and American Library associations, the Canadian Medical Association, The Canadian Adult Education Association, Engineering Institute of Canada, Canadian Public Health Association, Institute of Aeronautical Science, and the Canadian Pharmaceutical Association include a journal with the members' professional fees. – Editor.

Do we care enough?

The question that bothers me is not new. I have long wondered what kind of leadership nurses give in the community, and whether they show the concern for social problems that is rightly expected of professionals. For example, what have nurses done to change a system that condemns to inactivity many elderly persons who could contribute to society by continuing to work at a job that they enjoy? Virtually nothing.

Why have nurses remained aloof from this issue? First, most nurses probably have not thought of compulsory retirement as an issue within the realm of nursing interest. Second, those who are concerned about the problem feel helpless to do anything about it. Finally, some nurses do not see anything amiss about compulsory retirement at 65.

If people wanted to spend their last 10 or 20 years in leisure activities and were prepared to use this leisure, there would be no problem. We know that this is not generally so; a walk through a home for the aged is convincing. We hear and read a great deal about the need of education for leisure. The trouble is, we do next to nothing about it. Surely this is a nursing responsibility.

An even more basic problem is that of attitude. It is Western society's attitude toward the aged that condemns them to a life apart. Our scale of values gives priority to youth, and attitudes are extremely hard to change. To get people in our society to look forward to old age would take a revolution.

There are good reasons for old age to be a desirable period of life. The individual has acquired knowledge and experience, and has usually learned to live harmoniously with others, to cope with frustrations, to accept knocks without bitterness, and to press on, day after day,

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no matter how hard the going. If we do not look to these people who have "weathered the storm," are we not bypassing a rich source of help in the art of living?

Think of the difference it would make to the aged person if sons and daughters – not only his own – regularly asked for advice on how to handle the perplexing situations of daily life. Wouldn't this make the elderly person feel needed?

As nurses, we have a responsibility to change the public's attitude toward the aged. We have the knowledge, we know the problem. Do we care enough? – Sister Muriel Gallagher, Moose Jaw, Saskatchewan.

Bursary for nursing students

In the fall of 1962, under the leadership of Miss Dorothy Hart and Mrs. Maxine Thomson, many students of Miss Mildred I. Walker contributed to a fund to establish a bursary for nursing students at The University of Western Ontario in Miss Walker's name. Miss Walker, herself, left $5,000 in her will for this fund and, at the time of her death, many friends and associates made a contribution in her memory.

The capital of this fund is now $8,848, which earns an estimated annual income of $500. Nurses who contributed to this fund will be interested in this information.

The faculty and students at The University of Western Ontario School of Nursing are grateful that this bursary was established. It is a very fitting tribute to Miss Walker, whose interest in students was outstanding. – R. Catherine Aikin, Dean, School of Nursing, UWO, London, Ont.

Second class citizens?

Thank you for the articles on Clinical Laboratory Procedures and Hyperbaric Oxygen Units (February 1969). I am an R.N. from the Netherlands and was pleased when you mentioned Amsterdam. Gas gangrene is a real danger in certain parts of Holland.

Also, as a midwife from Holland, I know that many hospitals appreciate our training. Why do midwives here not get any recognition from official bodies in the nursing field? If a Canadian nurse takes postgraduate training in obstetrics and gets rewarded, why not the foreign nurse? How long will we be treated as second-class citizens in this respect?

It is not my intention to take the place of the doctor; the understanding of a woman in labor and the ability to recognize abnormalities are often far more important than the delivery itself. I must admit, however, that I am proud I am also thoroughly trained for this, as are my colleagues from England. Perhaps it would be valuable to assess the abilities of foreign nurses and reward them rather than use their extra training and tell them, at the same time, that it is not any more than the Canadian R.N. learns during her basic training. – Susanna J.D. Meyer, R.N., Cochenour, Ontario.

Take a dive

For the past two years I've been working as a Canadian University Service Overseas volunteer in Barbados and now in Jamaica. At the present time, I'm keeping more than busy as a staff nurse in the premature baby unit of the children's hospital here in Kingston.

During the year I spent at the Montreal Children's Premature Nursery, I would have chuckled at anyone who said I'd be doing half the things I'm doing now. But I will never regret having joined CUSO. I hope that far more nurses will take the dive out of our warm, neat, sterile, well-organized life in Canada and come for a swim with most of the world's nurses in a much less pampered life. I've loved it!

At the moment, there are about four CUSO nurses in the Caribbean. We could use at least 10 more. There is no age limit.

Any volunteers? –Wendy Craster, Kingston, Jamaica. □



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THE CANADIAN ARMED FORCES

VB0413

news

CNA's Journals Reclassified As Third Class Mail

Ottawa. – The Canadian Nurses' Association's application to have *The Canadian Nurse* and *L'infirmière canadienne* remain classified as second class mail by the Canada Post Office was rejected in February.

Under the terms of the "Post Office Act as amended by chapter 5 of the Statutes of Canada 1968," the CNA journals do not qualify as second class mail because they are "published primarily for the benefit of the members of a particular profession."

The new postal rates, which came into effect April 1, raise the annual costs of mailing the journals by approximately $135,000.

More Nursing Schools Move within Framework ... Education

Ottawa. – Twenty-six diploma schools of nursing and nursing courses were in operation within the general education system at the post-secondary level in Canada, at the end of December 1968. These programs were in five provinces: Alberta, British Columbia, Ontario, Quebec, and Saskatchewan.

Total *admission* to these schools of nursing in 1968 was 1,901; total *enrollment* in these nursing programs in 1968 was 2,349. In Quebec and Saskatchewan, slightly more than half the admissions were to programs within the general education system.

The most recent figures on these two provinces have been supplied by Lois Graham-Cumming, director of research and advisory services for the Canadian Nurses' Association. In Quebec, 2,521 students were admitted to diploma schools of nursing in 1968. Of these, 1,402 were enrolled in the 20 general and vocational colleges (CEGEP) with nursing options. The CEGEP system was set up following the Royal Commission Inquiry on Education in the Province of Quebec (Parent Report), which recommended the integration of nursing schools into the general system of education and the integration of nursing courses at the post-secondary level. The first nursing courses within the general system were offered in 1967.

In Saskatoon, 244 of the 454 admissions to schools of nursing in 1968 were to the Institute of Applied Arts and Sciences. Nursing education in Saskatchewan came under the ministry of education in 1966. The first school of nursing under these auspices was opened in the fall of 1967.

In Ontario there were 37 admissions to the school of nursing at Toronto's Ryerson Polytechnical Institute in 1968. (This was the first school of nursing in Canada to be set up under the general education system.) In British Columbia, 99 nursing students were admitted to the British Columbia Institute of Technology. Alberta admitted 57 nursing students to the Mount Royal Junior College, 34 to Red Deer Junior College, and 28 to St. Jean's College. New Brunswick is continuing to press for all nursing education to be under the jurisdiction of educational institutions.

The idea of establishing schools of nursing under the system of general education is not new. A report by Dr. Weir in 1932 said that the educational principles governing the preparation of nurses did not differ fundamentally from those underlying the education of other disciplines. In 1952, the CNA recommended that nursing education should be provided in institutions whose primary objective is education. Since then, the Association has maintained the belief that nursing education should be developed within the educational systems of the country and has pressed for this change.

Newfoundland Donates $1,840 To CNA For ICN Costs

St. John's. – The Association of Registered Nurses of Newfoundland donated one dollar per member ($1,840) to the Canadian Nurses' Association in March, for the 14th Quadrennial Congress of the International Council of Nurses to be held in Montreal June 22-28. The ARNN will also donate 10,000 pamphlets about Newfoundland and Labrador.

Newfoundland is the fifth province to make a financial contribution to CNA for ICN. The others are: New Brunswick, Quebec, Alberta, and British Columbia.

RNABC Contributions To ICN Reach $8,400

Ottawa. – An additional gift of $2,900 has been made by the Registered Nurses' Association of British Columbia to the 14th Quadrennial Congress of the International Council of Nurses, to be held June 22-28 in Montreal.

A gift of $5,500 was reported in the news section of the March issue.

RNABC has requested that the funds be used as follows:

- $5,000 for the CNA to use in any way needed.
- $500 to provide music for the Congress.
- $1,500 to provide entertainment tickets for guests from abroad who have limited funds in Canadian currency.
- $1,400 to assist with living expenses for guests from abroad who have limited funds in Canadian currency.

Whoo-fur – ICN's Furry Mascot



Ottawa. – Whoo-fur, the furry creation of the Saskatchewan Plains Indians, has been chosen official mascot for the International Council of Nurses' XIV Quadrennial Congress in Montreal in June. Whoo-fur is a strip of rabbit fur with two large owlish eyes. He will be given to each registrant at the Congress and will be worn on her lapel to help identify her as a member of ICN.

Lester Pearson Cancels ICN Commitment

Ottawa. – Lester B. Pearson, originally scheduled to be the keynote speaker at the 14th Quadrennial Congress of the International Council of Nurses to be held in Montreal June 22-28th, will be unable to attend.

Harriet J.T. Sloan, ICN Congress Coordinator, received word that Mr. Pearson

has a European commitment at the same time, and this necessitates his change in plans.

As yet, a replacement for Mr. Pearson has not been named.

Western Region of CCUSN Holds Annual Meeting

Vancouver. – The annual meeting of the Canadian Conference of University Schools of Nursing, Western Region, took place at the University of British Columbia February 8-9, 1969.

The theme of the meeting was continuing education. Dr. Donald Williams, professor and head of the Centre for Continuing Education in the Health Sciences, University of British Columbia, was keynote speaker. He discussed three main points: 1. What is continuing education for health professionals? 2. Why is there such urgency – why so much interest? and 3. What is the role of the university in continuing education?

Margaret Neylan, head, Continuing Nursing Education, University of British Columbia, outlined the purpose of continuing education in nursing as an opportunity for nurses to keep abreast of the times. Mrs. Neylan said that educational experiences must be flexible, meet needs of persons with varying levels of education, and be stimulating.

Another speaker, Rita Darragh, assistant director of the school of nursing at Montana State University, Montana, discussed regional planning for continuing education. She pointed out that the Western Interstate Commission on Higher Education (WICHE) is attempting to equalize educational opportunities among the states. The council on higher education in nursing of WICHE is concerned with upgrading the education of persons who hold leadership positions in nursing education and nursing service. The council agreed that baccalaureate preparation should be basic education for leaders, but, in reality, this was not possible.

Miss Darragh said that pilot demonstrations in leadership have been held by WICHE since 1957. These demonstrations were one week in length and extended over a three-year period. Extensive evaluation indicated that the demonstrations led to improved leadership and patient care. Twice yearly seminars for leaders and consultants were also held, Miss Darragh said, and were sponsored by the Kellogg Foundation and later by federal traineeships. Results indicated a greater understanding of nursing service problems and nursing education goals, and greater interest in continuing education as a means to improve patient care.

Following the addresses, members of the CCUSN formed small groups to discuss the implications of the conference presentation and to consider ideas that might be promoted.

The following officers were elected for the remaining part of the two-year term, 1968-70: Hazel Keeler, past president; Alice Baumgart, president; Peggy Ann Field, vice-president; and Jessie Hibbert, secretary-treasurer. Members at large are: Margaret Street, B.C.; Grace Tannehill, Alta.; Jean Pipher, Sask., and Joy Winkler, Man.

CCUSN is a national organization whose purpose is to promote the advancement of nursing education in universities. The annual CCUSN meeting will coincide with the International Council of Nurses' Congress in Montreal in June.

Nurses Discuss Future of Nursing Education

Nova Scotia. – The future of nursing education in Nova Scotia was discussed April 1 at a meeting at the Victoria General Hospital Nurses' Residence. The session focused on the two-year nursing education program. It was cosponsored

(Continued on page 12)

Some Thoroughly Modern Millies



Here they are – those gay, daring debs of the roaring 20's, with their scandalously short skirts, fivrolous beads, and bobbed hair.

These are some of the nurses from countries 'round the world who flocked to the swinging city of Montreal in 1929 to attend the first Congress of the International Council of Nurses to be held in Canada. According to stories featured in the Montreal *Gazette*, they deluged the ICN's information desk with questions such as: "Which restaurant in Montreal has the most 'atmosphere'? " "Can one get a ferry from Quebec to the United States? " "I have a friend from England who is at the convention; could you find me her address? "

And the crucial issues at stake in the nursing world of 1929? Would you believe protecting student nurses from "measureless possibilities" of exploitation by hospital nursing schools? A paper given by Professor M. Adelaide Nutting from Teachers College, Columbia University, New York, made the headlines in the Montreal newspapers. Professor Nutting said that nursing schools must be taken out of hospitals and put into institutions concerned *wholly* with the education of nurses. She suggested establishing schools of nursing within universities, since students in hospital schools were looked upon as "sources of profit."

Times haven't changed all that much.

freedom now





Kotex tampons

(Continued from page 10)

by the Nova Scotia Hospital Insurance Commission and the Registered Nurses' Association of Nova Scotia.

The meeting took the form of an instructional program for those concerned with nurse education programs in hospital and the products of those programs. Attending were hospital administrators and directors of nursing service and of nursing education in hospital schools of nursing.

The pattern of Canadian nurse education in two-year programs was presented, and the effect of application of this change in the hospital and other health services was reviewed.

Nova Scotia has accepted the concept of a two-year program for hospital schools of nursing. This program will be introduced in two schools of nursing in September 1969, and by 1971 will be the pattern for all hospital nursing schools in the province.

The day-long meeting was opened by Richard A. Donahoe, provincial minister of health.

University Nurses Present Brief To Castonguay Commission

Montreal. — A brief presented February 4 on behalf of the Canadian Conference of University Schools of Nursing, Quebec region, to the Castonguay Commission on Health and Welfare in Quebec, recommends ways to meet the need for higher education of nurses in Quebec, new nursing categories, and nursing research.

The brief was presented in a public hearing by Claire Gagnon, director, and Olive Goulet, assistant professor, Laval University School of Nursing; Sister Marie Bonin, who is responsible for the baccalaureate program, and Sister Marie-Claire Rheault, lecturer in the nursing faculty, University of Montreal; Elizabeth Logan, director, and Helen Moogk, assistant professor of nursing, McGill University School for Graduate Nurses.

The brief recommends:

- That university schools of nursing already offering a baccalaureate program receive funds that will permit them to accept larger numbers of students.
- The establishment of baccalaureate programs, particularly in Quebec's French-language universities.
- Increased study grants, divided equally across the province, for nurses wishing to pursue higher education.

In the brief, a table of statistics for 1967, compiled by the Association of Nurses of the Province of Quebec, shows that only 5.7 percent of staff nurses, 10.6 percent of supervisors, and 20.6 percent of teachers practicing in Quebec hold a bachelor's degree; .5 percent of Quebec nurses hold a master's degree; and three nurses a doctoral degree.

- That competent authorities systematically review the categories of health workers required to meet the needs of the people of Quebec.
- That two classes of nurses be officially recognized: the university-trained nurse and the nurse technician or technologist; and that male candidates become legally integrated into these two classes.

According to the brief, Quebec now prepares one university-trained nurse for 10 nurse technicians.

- That a large number of well-trained guidance counselors be available to guide secondary school students, according to their aptitudes, either toward the CEGEP nursing option [General and Vocational Colleges throughout Quebec will replace all hospital schools of nursing by 1970] or toward the pre-university option necessary for entrance to the university school of nursing.
- That the department of education make it compulsory, after a certain time, for nurses teaching at the CEGEP level to hold at least a bachelor's degree; and that measures be taken to allow these nurse access to master's programs.
- That organizations in charge of plan ning research in Quebec take account o the need for developing research in th field of nursing.
- That the hiring policies of the depart ment of education favor nurses prepare at the university level for positions i public health nursing.
- That research funds be set aside t allow for publication of nursing books i French.

Commuting Students Study En Route



Montreal. — Commuting time is not wasted time for this group of senior nursing students from the State University of New York in Plattsburgh. The buses that carry the students once a week to Douglas Hospital, Verdun, near Montreal, have headphones installed in each seat for lectures and discussion en route. Two groups of 40 students make the trip once a week, accompanied by four instructors, for psychiatric experience. Seats in the fire-engine red buses are arranged in three groups for easier discussion. On the way to the hospital the discussion centers on the plans for the day, and on the return trip it centers on the results of the day's work. The photo shows Mary Christie, director of nursing at Douglas Hospital, welcoming a group of students.

MARN Surveys Staffing Patterns

Winnipeg. — A province-wide surve of staffing patterns just completed by th Manitoba Association of Registered Nur es has netted a 95 percent return. Th material is now being analyzed.

One area of concern has been th competence of out-of-country nurse this survey shows they are satisfactory i small rural hospitals; the smaller th hospital, the greater satisfaction reporte

The incidence of continuing educatio programs and their efficacy has also bee investigated; the survey indicates sma rural hospitals do not have formalize

(Continued on page 1

Now available

THE SECOND EDITION OF

COUNTDOWN

CNA'S YEARBOOK OF CANADIAN NURSING STATISTICS

One-third larger than last year's edition, **COUNTDOWN 1968** contains commentary and 133 statistical tables updated to present the latest available data on nursing manpower, education, and salaries.

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A cross-reference between **COUNTDOWN** and **FACTS ABOUT NURSING**, published by the ANA, is available from CNA.

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news

(Continued from page 12)

programs other than doctors' lectures.

It is anticipated that MARN will give more leadership in the area of inservice education in the next year and will conduct workshops on this subject.

Hamilton Nurse Educators Return To Work

Hamilton. – The 18 faculty members of the Hamilton and District School of Nursing who went on strike March 4 returned to work on March 25, after reaching agreement with their employer over salaries, transportation expenses, benefit plans, and hours of work.

The contract, effective March 2, 1969 to March 1, 1970, provides a salary increase of 8-1/2 percent, 2 percent higher than salaries set by the Ontario Hospital Services Commission. The new salary range for instructors with a bachelor of nursing science degree is $7,800 to $9,120, with 5 yearly increments of $22; for instructors with a master's degree, the new range is $8,280 to $9,600. Salaries include a monthly educational bonus of $80 for instructors with a bachelor's degree, and $120 for instructors with a master's degree. In lieu of retroactive increases, the nurses received a lump sum of $200.

Other provisions in the contract are:

- A 10 cent per mile travel allowance from the school to the destination and return.
- The supplying of teachers' textbooks by the school.
- A 38-3/4-hour work week, including 12 hours a week for lecture preparation.
- Time off for overtime.
- Payment by the school of 66-2/3 percent of a hospital, medical, and group insurance plan.
- The hiring of a substitute teacher if an instructor is absent more than a week.
- Vacation pay based on the current salary rate.
- A $24 per month allowance for "leaders when required by the school." (The term "leader" refers to the two senior teachers in the school who help to coordinate the first- and second-year program and instructors.)
- Three working days off at Christmas and four at Easter. (These days are in addition to the usual holiday time allowed for Christmas, New Year, and Easter.)

The Registered Nurses' Association of Ontario worked closely with the instructors, helping them to organize for certification and to draw up proposals. Anne Gribben, RNAO's director of employment relations, told *The Canadian Nurse* that the contract achieved certain goals, even though there was no great monetary gain.

"The principle of comparing these teachers with other educators when deciding on salaries was not accepted," Miss Gribben said. "However, other gains were made. First, the contract recognized the teachers' need to have time to prepare lectures. It is a good thing to have this spelled out. Second, recognition was given to the senior teachers [called "leaders" in the contract] who have additional responsibilities. This recognition is a real breakthrough," Miss Gribben said.

Extension Courses Continue To Be Popular

Toronto. – The five hundred and seventeen nurses enrolled in the 1968-69 extension course in Nursing Unit Administration completed spring workshops in May.

To date, 537 nurses are enrolled in the 1969-70 class; 11 of these nurses are in the French program. Fall workshops for this class have been planned for August 25-29 in Vancouver and Ottawa, September 8-12 in London, Halifax, and Montreal (French), and September 15-19 in Toronto and Winnipeg.

(Continued on page 16



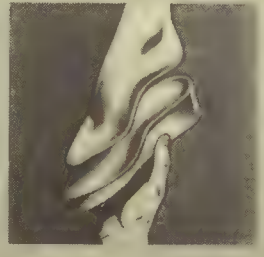
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to hasten healing when the lesion is infected...inflamed

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Elase (powder for solution)
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Elase-Chloromycetin® Ointment

Ulcerative lesions, contaminated lacerations and unhealed burns contain fibrinous exudates and necrotic tissue elements that support bacterial growth—a major factor in delayed healing. Through its enzymatic debriding action ELASE helps remove this nutritive base on which bacteria thrive . . . thus it supports and hastens healing.

ELASE is supplied in ointment form and as dry material for solution. Each gram of ointment contains 1 unit (Loomis) of fibrinolysin and 666 units of desoxyribonuclease. Each vial of ELASE for solution contains 25 units (Loomis) of fibrinolysin and 15,000 units of desoxyribonuclease.

ALSO AVAILABLE: ELASE-CHLOROMYCETIN Ointment contains 1% CHLOROMYCETIN (chloramphenicol, Parke-Davis) in combination with ELASE Ointment.

INDICATIONS: To lyse fibrin and liquefy pus in order to aid removal of necrotic debris. Useful in the removal of exudate from skin surfaces as in wounds, ulcers, burns, vaginitis, cervicitis; also used to irrigate abscess cavities, superficial hematomas, sinus tracts, and fistulas.

ELASE-CHLOROMYCETIN Ointment provides effective enzymatic debridement plus direct antibacterial action to assist healing of infected surface lesions. May be used topically and intra-vaginally when both a debriding agent and a topical antibiotic are indicated.

APPLICATION: *Skin surface lesions*—apply topically as ointment or solution as indicated, one or more times a day. After application, enzymatic activity becomes progressively less and is probably exhausted for practical purposes at the end of 24 hours. Remove necrotic debris between applications. *Mild to moderate vaginitis and cervicitis*—deposit 5 cc. of ointment deep in the vagina once nightly after retiring for 5 applications; re-examine for possible need of further therapy.

PRECAUTIONS: Observe usual precautions against allergic reactions, particularly in persons sensitive to materials of bovine origin, antibiotics or thimerosal. With respect to ELASE-CHLOROMYCETIN Ointment, following topical use of chloramphenicol, the patient may become sensitized to the drug. ELASE-CHLOROMYCETIN should be used only for serious infections caused by organisms which are susceptible to the antibacterial action of chloramphenicol.

WARNINGS: ELASE should not be used parenterally. ELASE-CHLOROMYCETIN should not be used as a prophylactic agent. Chloramphenicol, when absorbed systemically from topical application, may have toxic effects on the hemopoietic system. Prolonged use may lead to an overgrowth of non-susceptible organisms including fungi.

ADVERSE REACTIONS: Side effects from ELASE have been minimal, consisting usually of local hyperemia. Allergy to the chloramphenicol portion of ELASE-CHLOROMYCETIN Ointment may show itself as angioneurotic edema or vesicular and maculo-papular types of dermatitis.

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Detailed information available on request.

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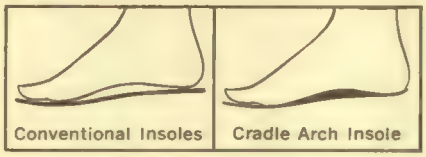
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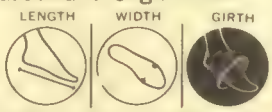
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news

(Continued from page 14)

The Nursing Unit Administration Course, which is sponsored jointly by the Canadian Nurses' Association and the Canadian Hospital Association, provides an organized program on the principles of administration and leadership, with the goal of more effective patient care. It is intended for nurses who are working in administrative positions and who are unable to attend a university to upgrade their skills.

The course consists of an initial five-day workshop held in the fall, followed by 12 correspondence lessons and another workshop in the spring. Workshops are held in seven locations on a regional basis.

RNABC Loans Offered

Vancouver. – The Registered Nurses' Association of British Columbia is offering a number of bursary/loans for assistance in nursing study.

RNABC members undertaking full-time post-basic study and students in the final year of a basic baccalaureate degree program in nursing are eligible for the awards. A commitment of one year of service in a nursing position in British Columbia must be given by each recipient.

Completed application forms must be in to RNABC by June 15.

Nurses' Christian Fellowship At ICN

Toronto. – The Nurses' Christian Fellowship of Canada, in collaboration with Nurses' Christian Fellowship International, will have a Friendship Lounge in Place Bonaventure, near Concordia Hall, during the 14th Quadrennial Congress of the International Council of Nurses in Montreal June 22-28. Here, delegates may relax between sessions, meet old friends, and make new ones.

NCF hostesses, conversant in the four main languages of the Congress, will be present to welcome delegates and answer questions about Canada and Montreal.

Two Scholarships Offered in Quebec

Montreal. – Two scholarships of $300 each are being offered this year by District Nine of the Association of Nurses of the Province of Quebec. They are open to nurses of the district who will be studying for a baccalaureate degree.

Candidates must have at least two years' experience in nursing and must be accepted at a university school of nursing. Preference will be given to those who intend to make a career out of nursing.

Candidates will be chosen by a selection committee of five or six experts in nurse education from District Nine. Deadline for applications is August 1. □

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names

Grace M. Fairley, a pioneer in Canadian nursing, died in Vancouver March 15 at the age of 87. She came to Canada in 1912 from her native Scotland where she held several nursing positions.

Miss Fairley began her career in Canada as superintendent of nurses, first at Montreal's Alexandra Hospital from 1912 to 1919, then at The Montreal General Hospital from 1919 to 1924, and later at the Victoria Hospital in London, Ontario, from 1924 to 1929.

As director of nursing and principal of the School of Nursing at The Vancouver General Hospital from 1929 until her retirement in 1943, Miss Fairley introduced many progressive changes. Actively concerned about nurses' working conditions, she saw the eight-hour day for nurses become a reality. She strongly supported higher education for nurses. Under her leadership, The Vancouver General Hospital School of Nursing increased its number of graduates to become one of the largest schools in Canada.

Through the important offices she held in Canadian and international associations, Miss Fairley increased the stature of Canadian nursing. She was vice-president of the American Hospital Association from 1916 to 1917. In 1941, she was appointed third vice-president of the International Council of Nurses, a post she held until 1953.

As chairman of the nursing education section of the Canadian Nurses' Association from 1930 to 1934, she laid the foundation for many recent educational developments. As president of the CNA from 1938 to 1943, one of her objectives was to help develop nursing throughout Canada, rather than think "in terms of east or west."

Miss Fairley was active on the executives of the provincial registered nurses' associations of Quebec, Ontario, and British Columbia. She also served as president of the Canadian Association of Nursing Education.

In 1943 Miss Fairley received the Agnes Snively memorial medal, awarded to leading members of the nursing profession in Canada.

One of her former students, Dr. Helen K. Mussallem, executive director of the CNA, recalls Miss Fairley's belief that the nurse had a great responsibility to the community — as a professional and as a citizen. "Miss Fairley saw the nurse's role extending beyond the hospital, and introduced into her nursing education program many types of clinical experiences that were real innovations at that time," Dr. Mussallem said. "She was a very courageous person, and when convinced of the need for change, she was not afraid to take the difficult road. For example, in 1942 she was successful in having Japanese and North American Indian students admitted into The Vancouver General Hospital's School of Nursing."

"Miss Fairley was one of the real giants in Canadian nursing."

New Zealand Nurse Visits CNA



Jean Sutherland, acting assistant director of the Division of Nursing, Department of Public Health in Wellington, N.Z., is touring Canada — one of four countries she chose to visit on her four-month World Health Organization fellowship. At a news conference at CNA House March 28, Miss Sutherland said she had visited the University of British Columbia's school of nursing where she was interested in the multi-discipline approach to the teaching of public health nursing. Also on her study tour are the United States, England, and Finland.



Anne Gribben (Reg.N., Toronto Western H., B.A., U. Toronto; Cert. Nurs. Service Admin., U. Toronto) is the new director of employment relations for the Registered Nurses' Association of Ontario. Previously Miss Gribben was associate director of RNAO's employment relations department.

Miss Gribben was born in Brantford. She graduated from Toronto Western Hospital in 1945, then worked there as a staff nurse, head nurse, and for 13 years as supervisor of the emergency and emergency observation wards.

She has also worked on committees for the Canadian Nurses' Association and the RNAO.



Margaret M. Lonergan (Reg.N., St. Joseph's H.; B.Sc.N.Ed., Seattle U.; M.N., U. Washington) has been appointed full-time nursing consultant with the Mental Health Branch, British Columbia Department of Health Services and Hospital Insurance, Victoria.

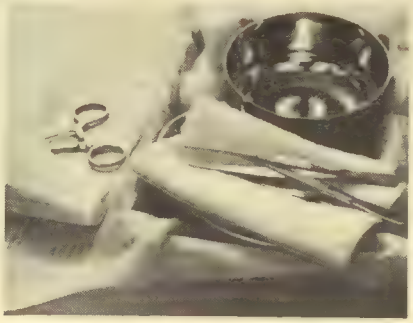
Miss Lonergan was formerly director of nursing in the B.C. Mental Health Branch in Essondale. In Vancouver, Miss Lonergan was a science instructor, and

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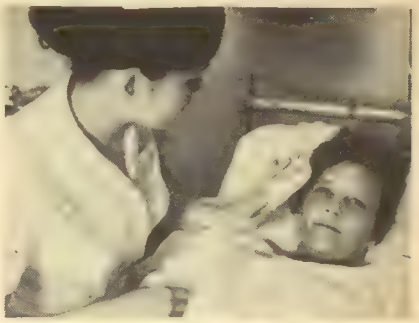
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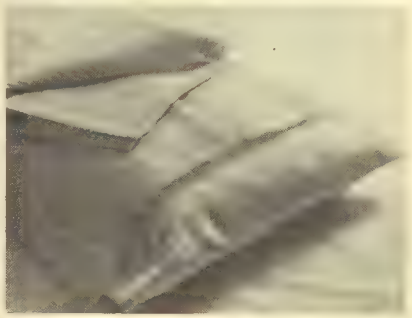
Operating Room. Use J CLOTH* Hospital Towels as a prep sponge, vaginal wipe and to catch overflow of prep materials. Excellent as surgeon's hand towel and for drying his forehead. Available in three colours. Green is recommended for O.R. use.



Obstetrical Department. J CLOTH* Hospital Towels are sterilizable which makes them ideal to receive baby during delivery—and as a hand towel for surgeons and nurses. Also can be used as a perineal wipe and prep towel. They won't fall apart when wet.



Isolation Wards. J CLOTH* Hospital Towels cost so little they can be thrown away after a single use. No wonder so many hospitals are using them in their isolation wards as a sterile, single-use face cloth or hand towel. They're far better than paper.



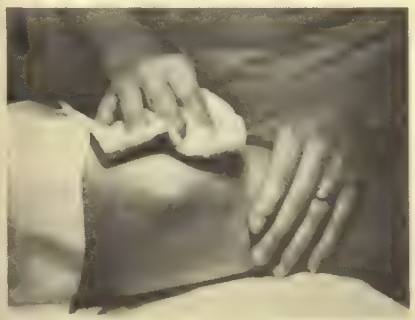
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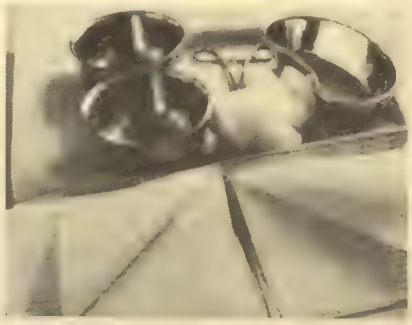
Orthopaedic Department. Use them as a hand towel for surgeons and cast room technicians. They are surprisingly durable and retain shape after many dryings. Low unit cost makes them more economical than rental towels.



Nursery. Nurses find J CLOTH* Hospital Towels very good as a burp cloth. Other uses: face cloth for newborn babies, as a mattress cover for bassinets and for cleaning babies' buttocks. They're far softer than terry cloth or paper.



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names

(Continued from page 18)

later associate director of nursing education at St. Paul's Hospital School of Nursing.

An active member of the Registered Nurses' Association of British Columbia, Miss Lonergan has worked on various task committees, and has been on the Board of Nurse Examiners and the Committee on Nursing Education.



Lydia Wiebe (R.N., B.N.) has been appointed director of nursing service for Grace General Hospital, Winnipeg.

Miss Wiebe graduated from St. Boniface Hospital, Manitoba. She received her bachelor of nursing degree from McGill University, Montreal.

She was formerly supervisor of a medical nursing unit at the Winnipeg General Hospital.



Winnifred M. Reid (R.N., B.Sc.N., U. Alberta H.) has been appointed director of nursing at Burnaby General Hospital. She began her duties on Sept. 2, 1968, prior to the retirement of Mrs. Ruth Laird from that position.

Mrs. Reid was formerly assistant director of nursing at Edmonton General Hospital in Alberta. She studied postgraduate psychiatric nursing at Alberta Hospital, Ponoka, Alberta.

Named medical-surgical instructor at the school of nursing, University of British Columbia, is **Caroline Domke** (R.N., Hinsdale H., Ill.; B.Sc., Walla Walla College, Washington).

Mrs. Domke previously worked as staff nurse, head nurse, and instructor at Hinsdale Hospital, Illinois, and as head nurse at Walla Walla General Hospital, Washington.

Jean M. Hill, dean of the school of nursing at Queen's University, Kingston, has announced two new appointments to the faculty. **Mary Elizabeth Johnson** (B.Sc.N., U. Western Ont.; M.Ed.N., Columbia U., N.Y.) has been named assistant professor and **Patricia S.B. Anderson** (B.Sc.N., U. British Columbia; M.Sc.(Appl.), McGill) has been named lecturer.

Miss Johnson, a native of Manitoba, comes to Queen's from Rutgers University, New Jersey, where she was instructor in public health nursing. Before her appointment to Queen's, Miss Anderson was teacher and supervisor of in-service education at The Hospital for Sick Children, Toronto; inspector of schools of nursing in Ontario; and, most recently, assistant director of the College of Nurses of Ontario.

Three staff members recently joined the faculty of the school of nursing, Lakehead University.



Liny E. Lyss (R.N., Switzerland; B.Sc.N., Chico State College, California; M.Sc.N., U. California, San Francisco) was appointed assistant professor. She will be teaching psychiatric nursing.

Mrs. Lyss went to California in 1955 from Switzerland. In her homeland she had had several years experience as a staff nurse, head nurse, and supervisor.

She spent some time as assistant professor in nursing at Sacramento State College and came to Lakehead University from Madison, Wisconsin, where she organized and implemented an inservice education program financed by a National Institute of Mental Health Grant. The written report of this program will be published early in 1969.



Margaret I. Boone (Reg.N., Mack Training School for Nurses, St. Catherines, Ont.; B.Sc.N., Lakehead U.) has accepted an appointment as lecturer. After graduation, Miss Boone worked as a general staff nurse at The Hospital for Sick Children, Toronto.



Carole J. Aalto Faulkner (Reg.N., St. Joseph's H., Port Arthur, Ont.; Cert. Nurs. Educ., U. Toronto; B.Sc.N., Lakehead U.) was appointed lecturer.

Following graduation in 1955, Mrs. Faulkner spent one year as staff nurse at Lakehead Psychiatric Hospital, returning there as instructor in psychiatric nursing in 1957. In 1965 she joined the staff of the school of nursing, General Hospital of Port Arthur, as a teacher in pediatric nursing, a position she held until accepting her present appointment.

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dates

May 14-16, 1969
A continuing education course for nurses, University of British Columbia. Theme: Pre-Operative nursing care. Course fee: $23. Non-registrants may attend the keynote lecture May 14. For further information write: Division of Continuing Education in the Health Sciences, University of British Columbia, Task Force Building, Vancouver 8, B.C.

May 21-23, 1969
Canadian Hospital Association, 2nd national convention and 26th assembly meeting, Civic Centre, Ottawa.

May 20-23, 1969
Canadian Public Health Association annual meeting, Hotel Nova Scotian, Halifax. Theme: The child in contemporary society. Write to: Canadian Public Health Association, P.O. Box 2410, Halifax, N.S.

May 21-23, 1969
Saskatchewan Registered Nurses' Association, annual meeting, Bessborough Hotel, Saskatoon.

May 23-25, 1969
Reunion of Moose Jaw Union Hospital Alumnae Association, Moose Jaw, Sask. Members of all classes 1909-69 are welcome. Write to: Alumnae Reunion Committee, c/o Mrs. A. Kitts, 870 Stadacona St. W., Moose Jaw, Sask.

May 28-29, 1969
First national institute on Tuberculosis and Respiratory Disease, Christmas Seal Auditorium, Vancouver. Sponsored by the Nursing Section of the Canadian Tuberculosis and Respiratory Disease Association, British Columbia branch. Theme: What's Ahead in Nursing Care of Respiratory Diseases. For hotel reservations write: Mrs. C.G. LaRiviere, Willow Chest Centre, 2647 Willow Street, Vancouver 9.

May 29-30, 1969
Manitoba Association of Registered Nurses, annual meeting, Brandon General Hospital School of Nursing Building, Brandon.

May 28-29, 1969
Registered Nurses' Association of Nova Scotia, annual meeting, Yarmouth.

June 2-3, 1969
Refresher Course for Inactive Public Health Nurses, School of Nursing, University of Toronto. Residence accommodation available. Write to: University of Toronto, Division of Extension, 84 Queen's Park, Toronto 5.

June 6-7, 1969
Conference for dialysis personnel, Park Plaza Hotel, Toronto. Sponsored by the Ontario Dialysis Association. For further information, write to: Miss Bernadette Plaus, 280 Wellesley Street, No. 2603, Toronto 5.

June 10, 1969
Annual meeting, Association of Nurses of Prince Edward Island, Charlottetown.

June 9-13, 1969
The Catholic Hospital Association annual convention, Minneapolis auditorium, Minneapolis, Minnesota. Theme: The Evolving Health Care System.

June 9-20, 1969
Seminar for senior nursing executives, School of Nursing, University of Western Ontario, London. For application forms and further information, write to: Miss R. Catherine Aikin, Dean, School of Nursing, The University of Western Ontario, London, Ontario.

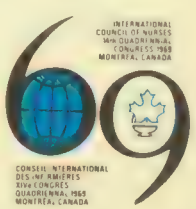
June 13, 1969
Annual dinner meeting, Nurses Alumnae Association of the University of Ottawa and Ottawa General Hospital Schools of Nursing, Skyline Hotel, Ottawa. A new slate of the executive and officers will be elected.

June 16-18, 1969
Conference on Nursing Education for visitors to the ICN Congress, University of Toronto School of Nursing. On June 19 and 20, the School will try to meet individual requests for special activities, such as small group conferences, visits to nursing schools and community agencies. Write to: The Secretary of the School, University of Toronto School of Nursing, 50 St. George Street, Toronto 5. Send name and address, dates of arrival and departure, and whether there are any financial problems.

June 21, 1969
50th anniversary celebration, The alumnae association of the Women's College Hospital School of Nursing, Toronto. Jubilee Dinner and Dance, Inn-on-the-Park, Toronto.

June 25-27, 1969
Final reunion of The Children's Hospital Alumnae Association, The Children's Hospital of Winnipeg School of Nursing. Held to coincide with the graduation of the last class from the School of Nursing. In future, a 10-week program in the nursing of children will be offered to students in Manitoba diploma schools.

June 22-28, 1969



International Council of Nurses' Quadrennial Congress, Montreal. Fee: $60. Write to: ICN Congress Registration, 50 The Driveway, Ottawa 4, Ont.

August 8-10, 1969
Reunion of Moncton Hospital School of Nursing Alumnae, New Brunswick. Members of all classes, 1909-1969, welcome. Write to: Alumnae Reunion Committee, c/o The Moncton Hospital, Moncton, N.B.

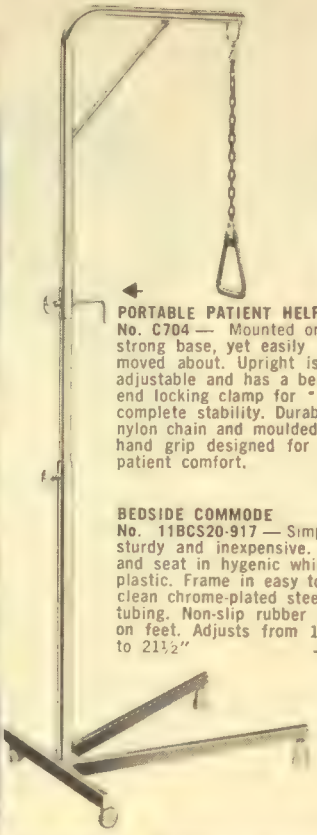
October 3-5, 1969
Second Annual Postgraduate Course for Emergency Room Nurses. Given by the Chicago Committee on Trauma of the American College of Physicians and Surgeons at John B. Murphy Auditorium, 50 East Erie Street, Chicago. The course will be open to graduate nurses employed in hospital emergency rooms, industrial health, and schools.

October 23-25, 1969
Association of Nurses of the Province of Quebec, annual meeting, Convention Floor, Queen Elizabeth Hotel, Montreal.

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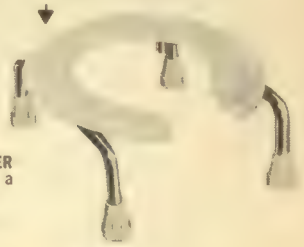


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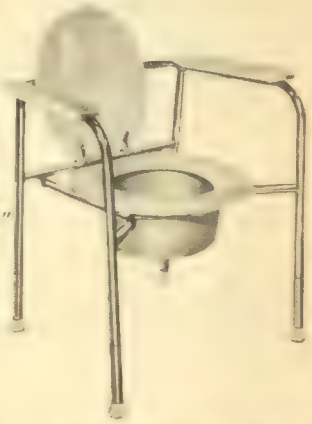


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new products

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The needles, which come in individual, sterile blister packages, can be used with the more than 400 existing types of Vacutainer specimen tubes, with and without anticoagulants.

For further information write: Becton, Dickinson & Co., Canada Ltd., Clarkson, Ont.

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Teleskom can reduce patient calls up to 50 percent by allowing nursing personnel to spend more time in patient care.

In addition to permitting direct voice communications, the control panel instantly shows the location of each patient calling and then enables the operator to pinpoint the locations of all nurses and aides through "presence lights." When the nurse or aide enters a room she presses her presence button, which records her location at the central panel and on a corridor dome light; she cancels it upon leaving. The presence lights, shown on a schematic layout of the hospitals' floors, enable the operator to spot at a glance personnel closest to the patient so that assistance can be provided promptly.

A single operator can handle all internal calls for a hospital of up to 500 beds, and can handle approximately 60 percent of patient requests without disturbing the nursing staff.

For further information: Tele Tracer International, Inc., 16 East 40th St., New York, N.Y. 10017.



Child uses the internal hospital communications system.

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Myambutol is contraindicated in patients known to be hypersensitive to this drug and in patients with known optic neuritis, unless clinical judgment determines that it may be used.

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For further information write to: Cyanamid of Canada Limited, Medical Products Department, 5550 Royalmount Avenue, Town of Mount Royal, Quebec.

Electronic Stethoscope And Amplifier

This new Electronic Stethoscope/Amplifier System is a lightweight, compact, battery-operated unit ideal for teaching applications and consultation purposes.

The Medetron unit can be used separately as an Electronic Stethoscope. It provides both high and low level amplification (up to several thousand times) of heart or other chest sounds, fetal heartbeats, etc. The Medetron permits easier examination of elderly, obese and comatose patients, and of children. It extends the normal hearing range and compensates for hearing loss.

The Medetron Amplifier (Model M-5) permits up to six persons to participate in the stethoscope examination either as students or consultants. Used by the attending nurse, it facilitates close cooperation with the physician and simplifies verbal description by him

For further information, write to: Mr. Marshall Benson, Manager, Sales and Service, Fraser Sweatman Ltd., 77 Grenville Street, Toronto 5, Ont. □

in a capsule

Parlez-vous français?
Español?
Deutsche?

Heading for the ICN next month? You still have time to brush up (even if it's for the first time) on one – or more – of the four official languages. It always seems friendlier to greet a foreign visitor in his own language, even if the sailing after the first "Hello" is not exactly smooth.

Everything is being done to make the visitors feel at home in Montreal (although home was never like this!) There will be a large, multi-language group of hostesses, who will add bright splashes to the Congress with their colored shoulder sashes: blue for English, green for French, red for German, and yellow for Spanish. Hostesses who speak Swahili and Cantonese – among the many languages that will be represented by 63 countries – will meet national groups at transportation centers, assist delegates in registering at hotels, hold orientation meetings for the group, distribute Congress kits, and will be available throughout the week for help.

You, too, will have many chances to befriend a bewildered visitor. Perhaps the guide below will help. Bon Voyage!



Brush up on your languages for the ICN Congress.

ENGLISH	FRENCH	SPANISH	GERMAN
book	livre	libro	Buch
building	édifice	edificio	Bavwerk
church	église	iglesia	Kirche
city	ville	ciudad	Stadt
country	pays	país	Land
good-bye	au revoir	adios	auf wiedersehn
hello, good day	bonjour	buenos días	guten tag
hospital	hôpital	hospital	Krankenhaus
how are you?	comment allez-vous?	cómo está Usted	Wie Geht's
I am hungry, thirsty	j'ai faim, soif	tengo hambre, sed	Ich bin hungrig, durstig
interpreter	interprète	intérprete	Dolmetscher
luggage	bagage	equipaje	Gepäck
map	carte	mapa	Landkarte
meal	repas	comida	Mahl
night	nuit	noche	nacht
nurse	infirmière	enfermera	Krankenschwester
price	prix	precio	preis
room (hotel)	chambre	cuarto	Zimmer
street	rue	calle	Strasse
subway	métro	metro	Untergrundbahn
thank you	merci	gracias	danke
today	aujourd'hui	hoy	heute
tomorrow	demain	mañana	morgen
yes, no	oui, non	si; no	ja; nein
what time is it?	quelle heure est-il?	qué hora es	was ist die uhr
where is...?	où est...?	dónde está	wo ist...
woman, Mrs...	femme, Madame...	mujer, señora...	Dame, Frau...



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By GERALD J. GRIFFIN, R.N., B.S., M.A., Former Head, Dept. of Nursing, Bronx Community College of the City University of New York; and H. JOANNE GRIFFIN, R.N., B.S., M.A., Instructor, Div. of Nurse Education, New York University. Publication date: March, 1969. Approx. 360 pages, 7" x 10", 62 illustrations. About $8.75.

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This unusual new book for your practical nursing students and paramedical trainees explains disease in basic concepts of cause and effect, in a semi-programmed format.

By CLARA GENE YOUNG, Technical Editor and Writer (Medical), retired, U.S. Civil Service; and JAMES D. BARGER, M.D., F.C.A.P., Pathologist, Sunrise Medical Center, Las Vegas, Nevada. Publication date: March, 1969. 295 pages plus FM I-XII, 7" x 10", 11 illustrations. Price, $8.75.

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Too little, for too long, from federal government

Shirley R. Good, B.S.N., M.Ed., Ed.D.

There is lethargy, bordering on antipathy, on the part of the federal government about the education of the members of the largest occupational group in the health professions – nurses. Proof of this lethargy can be found in the minimal sums of money that the government now provides through its National Health Grants to nurses studying at the baccalaureate, master's, and doctoral levels.

Federal funds 1964-68

In 1968, the Department of National Health and Welfare reported that a total of $6,317,313.30 was granted for nursing programs between 1964-68.[1] *(Table 1).* Contrary to usual appropriations, less money was given for capital grants and more for bursaries. Excluding monies allocated to National Health and Welfare nursing research, over one-half of the research funds were granted to non-nurses, presumably for research about nurses; and faculty salaries listed in *Table 1* are not solely for nurse faculty.

In its 1968 report, the Department stated: "Since 1964 there has been a noticeable increase in the number of bursaries granted by provinces for study at the baccalaureate and graduate level."[2] The report then listed the figures shown in *Table 2.*

From these figures, it is apparent that there has, indeed, been an appreciable increase in the number of bursaries awarded from 1964-65 to 1967-68. However, the 304 people who received grants at the baccalaureate level in 1967-68 represent only 8.5 percent of the total number of 3,565 nurses enrolled in Canadian university schools of nursing baccalaureate programs at that time; the 13 nurses who received grants at the master's level represent only 23.2 percent of the 56 nurses enrolled in master's programs. Since most Canadian nurses studying for doctoral degrees are enrolled in departments other than nursing in Canada or in U.S.A. programs, no enrollment figures are available for them.

Student nurses in hospital schools of nursing and university programs are, of course, eligible for the Canada Student Loans that come under the Department of Finance. However, in view of the actual cost to the student and her family, it is questionable whether the amount provided is sufficient. These loans have other deterrents: authorization of awards is dependent on family or guardian income; and there is no "forgiveness" clause relative to repayment of principle and interest for those entering a vital social service profession.

Why this lethargy?

For some reason, government has been unable, or unwilling, to recognize that monies granted to nursing education and research would ultimately benefit the public. In ignoring pleas for additional financial support, government has failed to equate quality preparation of health personnel with quality health care.

The government cannot explain away this indifference by pleading that it is unaware of the nursing profession's needs for funds for education and research. It has been kept well informed by the elected officers and professional staff of the Canadian Nurses' Association, who have presented numerous briefs and appeared personally to point out the need for financial assistance.

If the government had doubts about CNA's credibility, it had only to read the reports of *The Royal Commission on Health Service, 1964,* and *The Second Annual Report of the Economic Council of Canada, 1965,* to learn that these august bodies strongly advocated investment in human educational resources at the university level.

Money available for hockey

In briefs presented to the federal government in February 1968 and January 1969, CNA requested a minimum of 2.2 million dollars for nursing. Included in these briefs was a request that a minimum of $100,000 of this money be designated *exclusively* for nursing research in Canadian university schools of nursing.

The CNA representatives were given a

Dr. Good is Consultant in Higher Education with the Canadian Nurses' Association, Ottawa.

TABLE 1

Major Areas	Total Amounts Appropriated in a Four-Year Period
Capital Grants	$1,309,968.96
Professional Training Grant Bursaries (degree and short courses exclusive of hospital nursing programs)	3,606,393.13
Nursing Research	
To Nurses	92,204.00
To Other Than Nurses	57,927.00
Recruitment Programs	79,428.46
Faculty Salaries in Schools of Nursing	700,891.75
National Health & Welfare Nursing Research	200,000.00
*Educational leave with financial assistance to nurses of National Health and Welfare	240,500.00
	$6,317,313.30

*Federal employees are not eligible for assistance under the National Health Grant Program.

TABLE 2

Number of Bursaries Provided Through National Health Grants to Canadian Nurses for Study at the Baccalaureate, Master's and Doctoral Levels, 1964-65 and 1967-68*

Fiscal Year	Total	Level of Preparation		
		Baccalaureate	Master's	Doctoral
1964-65	21	17	4	0
1967-68	328	304	13	1

*Source: Health Insurance and Resources, Health Grant Program, Department of National Health and Welfare, October, 1968.

polite hearing. To date, no positive action has been taken by the government, and there is no indication that it intends to take action.

However, eight months following CNA's hearing, the Minister of Health and Welfare, The Honorable John Munro, somehow found $200,000 for the 45 members of Canada's national hockey team to improve their game in the last half of the 1968-69 season.

No one would deny that it is better to settle international differences and gain prestige on the hockey rink or playing fields than on the intercontinental ballistic missile firing ranges. But there may be more truth than fiction in what Reynolds, a character in Hugh Atkinson's book *The Games* says about international sports:

"You know what the Olympics are? A scoreboard for the State Department . . . It's war in track shoes, and everybody makes out except the athlete . . . You know how much they spent on the games at Tokyo? Six hundred million dollars – who do you think got it? The politicians, the contractors, the officials, the chambers of commerce, or some boy jumping over a bar? . . . You don't eat medals, boy. All I want out of a medal is a pro football contract . . ."[3]

This kind of federal investment for the few does not fit our concept of a "Just Society." On the other hand, investment – or the lack of it – in nursing education and research could affect the health of thousands of Canadians.

Compare with U.S.

Some may say that comparisons between Canadian and U.S. government policies cannot be made because of the differences in government financing, i.e., indirect aid versus direct aid in areas such as education. There is some validity in this argument. Even so, one fact cannot be denied: the U.S. federal government considers nurses and nursing education to be vital national resources; to date, the Canadian government has given little indication that it shows the same concern.

The most recent evidence of the U.S. federal government's concern about nursing can be found in the January-February 1969 issue of *Capital Commentary*.[4] Former President Johnson requested the U.S. Congress to include in its 1970 fiscal budget $47,730,000 for five program categories for nurse education. Of this, $7 million would be allotted for special project grants to schools of nursing; $9,610,000, for the student loan fund; $12 million, for the scholarship program; $11,120,000, for traineeships for professional nurses; and $8 million, for construction grants to schools of nursing. It is estimated that some 42,000 nursing students will receive educational financing, 13,000 will receive scholarships, and 29,000 will receive loans.

In comparison to U.S. efforts, the Canadian federal government has made a poor showing. In *four years* it has provided 13.2 percent of the amount that the U.S. government is considering for *one* year.

More realistic funding needed

How can we persuade the federal government that more realistic funding is needed for nursing education and research? One way would be for each of the 120,186 nurses in this country to write to her member of parliament and to the minister of health, requesting that positive action be taken. Another way is for the CNA to continue its efforts, as it undoubtedly will, at the national level.

If we fail to persuade government, we will fail to have properly prepared nurse practitioners and leaders for the future.

References

1. Letter from Principal Nursing Officer, Dept. of National Health & Welfare, November, 1968.
2. *Ibid.*
3. Atkinson, Hugh. *The Games.* New York, Simon & Schuster, 1967. p.11.
4. *Capital Commentary.* New York, American Nurses' Association, January-February, 1969. pp.4-5.

do your own thing in Montreal

For those of you going to the ICN Congress in June, we present a very special tourist's guide, which we hope will unveil a Montreal you might never have seen — its hidden charms and delights. You might never go home!

Valerie Fournier and Agathe Legault

The world of Montreal is worlds within worlds: a night world and a day world, a world of people or of things, of art or of food. In fact, it is a different world for each person who wishes to explore and find it.

You can discover a quaint old street in Vieux Montréal; take a gastronomic tour; sail the vast seas of art in bookshops, art galleries, theatres; or live dangerously and sample the night life. Which is your world?

Food!

The whole world of food awaits you in Montreal. The city is cosmopolitan in its taste buds, and the delights of cooking from many countries await you. Each Montrealer has his favorite restaurants. We asked a few of them to give us their choices.

A Montrealer by adoption, Mme Léon Dussault, loves to discover intimate, cosy restaurants where the cuisine is excellent and the price is reasonable. She knows the little places not frequented by tourists.

Mme Dussault recommends Le Plat d'Argent (1790 boulevard des Laurentides — 668.6874), where you can order a complete meal — including veal kidneys, a specialty of the house — for $3.50. Or, she says, try a charming little place called Le Molière (5870 Decarie Boulevard — 739.7970), where the decor is scarlet: the rich, warm color does wonders for the digestion, not to mention the spirit!

But above all Mme Dussault loves Le Paësano, a typically Italian restaurant, (5192 Côte des Neiges — 731.8221) and its Da Vinci Room with stained glass windows and frescoes of the great towns of Italy. Again, the price is reasonable, the music soft, the coffee delicious. And you'll be served by waiters and waitresses in the national colors of Italy — white, green, and red. There's an excellent bar in the basement, and in the summer you can sit outside on one of the two terraces.

A true lover of Montreal is M. Marcel Paré, a businessman who enjoys good food and wine. He knows the best restaurants in the city, and he knows many restauranteurs personally.

In the area in which M. Paré does most of his business, bounded by Bleury, Guy, Sherbrooke and Dorchester Streets, you will find a profusion of excellent restaurants. Many say this is the gastronomic center of the city. Here M. Paré will direct you to Chez Tonneau (1445 Crescent Avenue — 849.9086), a restaurant specializing in Belgian cuisine, where you'll find a copy of the famous "Mannekenpis" statue, which draws the tourists to Brussels' main square. If you want something different, try the white Belgian sausage, or the eels served on a bed of greens (anguilles au vert).

But M. Paré would not want you to miss sampling the cuisine of Vieux Montréal. In this part of the city he takes pleasure in dining at Les Filles du Roy (415 St. Paul Street East — 849.6556), whose proprietor, M. Jacques Trottier, is a friend of his schooldays. You will find superb French-Canadian cuisine, and picturesque, old-world French-Canadian decor.

French-Canadian satirist Jacques Normand suggests the Castel du Roy (2070 Drummond Street — 842.8106), where you're likely to find a varied clientele of artists and businessmen. The "in" people sit downstairs, and it's a fascinating place in which to eavesdrop. The chefs are skilled in the art of French cooking.

For a dramatic evening of dining out, La Barre-500 is recommended (2019 Taschereau Boulevard — 677.0101).

Mrs. Fournier is Public Relations Officer, Canadian Nurses' Association. Mlle Legault is Assistant Editor, *L'infirmière canadienne.*



Mountain Street, with its jumble of facades and signs, is one of the liveliest parts of the city.

Here everything – but everything – comes flambé, so watch yourself. In the middle of it all stands the maître d'hôtel, Monsieur René; with the flames flickering on his face he looks like a proud Corsican pirate. He really is Corsican, too, and knows the secrets of two magnificent salads with Corsican names: the Santiago and the Bonifacio. He is also master of the steak au poivre, filet mignon, and shish-kebab – all flaming, of course.

And if you really feel like living it up, you should try La Saulaie, on the road to Boucherville. Here the top men in the city meet to talk business and sometimes even bring their wives. The decor is sumptuous, and so is the bill.

Shellfish, men, and high altitudes

For lovers of shellfish and all the riches of the sea, the Café Desjardins or Chez Son Père are often recommended. But the restaurant with the oldest tradition for these delicacies is Chez Pauzé (1657 Ste-Catherine Street West – 935.9137). The decor is old-world, with much warm wood panelling.

M. Roger Poitras, printer for *The Canadian Nurse,* swears by a sea-food restaurant to the north of the city called Les Mouettes (1280 Laurentian Boulevard – 744.2845). During working hours he is continually worried about correct punctuation marks appearing on the pages of this journal, so when relaxing he loves to eat the delicious commas made by the shrimps in his favorite restaurant.

Returning to Catherine Street (1812 Ste-Catherine West) you'll find Le Paris, gay with its curtains covered with bright polka dots. It's a small restaurant with a faithful clientele – always the sign of good food. If it's to your taste, try a specialty: brains in black butter. The prices are modest, but be warned: if your waiter suggests a small endive salad with your meal, be prepared to add an extra dollar to your bill!

Another little restaurant that is inexpensive and has a pleasant atmosphere is Le Caveau (2363 Victoria Avenue – 844.1624). It's handy to the business hub of Montreal, and businessmen in the know like to spend their lunch-hours here.

But Agathe Legault, assistant editor of *L'infirmière canadienne,* finds the best place for businessmen-watching is the Jardin du Ritz, Ritz-Carlton Hotel, on Sherbrooke Street West. She says the handsomest men of this breed are to be found here at noon in the summer, where little ducklings swim around a murmuring pool, freshly starched tablecloths flap in the breeze, and scarlet and black clad waiters perform a ballet while whisking silently around the tables. Here sit these wealthy men, oozing culture and maturity, graying at the temples but still in their prime. The prices, naturally, are high. But in the afternoon, at tea-time, the atmosphere changes completely, as the handsome men are replaced by dignified ladies, charming as they discourse from under flowered hats while picking at French pastries or cinnamon toast.

For a somewhat more exciting atmosphere, go and drink a Volcano at the Kon-Tiki (1455 Peel Street) – a Polynesian restaurant within the Mount Royal Hotel. It's very different. The Volcano is an extremely expensive drink, but it will take you a long time to drink it – or it should – as you gaze fascinated at the strange white fog that pours out of the drink itself, hypnotized by the exotic decor.

If you care to leave the ground, hop on the nearest high-speed elevator at Place Ville-Marie. It will transport you to the top of the world of Montreal, to Altitude 737 – that's how many feet you are from the city streets. The midday buffet, at about $5.00, is a feast, and the whole place smells of the sauces, herbs, and fresh vegetables. And the view! The whole city is at your feet. By day pulsing with life, by night, when the city lights up, it becomes a fairyland for adults.

Fashion

In Montreal's world of fashion and of shimmering fabrics, Raoul-Jean Fouré is the prince of Canadian Haute Couture designers (1390 Sherbrooke Street West – 845.8841). If your stars are lucky and you ask him nicely, he may invite you to view part of his collection. But the haute couture comes at a

At right: M. Marcel Paré enjoys the good food and good service of Les Filles du Roy on Saint Paul Street with Jacques Trottier, (left), the proprietor.

The delicate steeple of Notre-Dame de Bon Secours pierces the sky above Saint Paul Street in Vieux Montréal. The domed building used to be an indoor market.





haute price!

If you prefer to make your own clothes, and love the feel of good cloth, M. Joseph Ascher will welcome you at his fabric boutique (1448 Sherbrooke Street West – 288.4624). He supplies fabrics to the best houses of fashion in Montreal, those of Fouré, Mario DiNardo, Lillian Farrar, Marie-Paule. He is carrying on the tradition of his brother Zika Ascher, who supplies London and Paris fashion houses. M. Ascher has mills in Scotland that produce the two great specialties of the house of Ascher: woollens and prints. For more beautiful fabrics you might visit France-Couture (Maison Ducharne, 1431 Mountain Street).

Art, Books, and Hidden Worlds

The world of art is fascinating and exciting in Montreal. You will see many different styles of painting, by the famous and about-to-be famous, and here you might even be lucky enough to find *your* picture, the one you always dreamed of for your living room, at a reasonable price.

Several art galleries are scattered along Sherbrooke Street, especially on the south side between Peel and Guy. But if you have the time, go further north near the intersection of Park and Laurier Avenues, and you'll find the gallery L'Art Français (370 Laurier Avenue West – 277.2179). This gallery is very special, because it seems to have the knack of discovering painters before they become famous. Long before people had heard of Ottawa Painter Henri Masson, L'Art Français had hung his works. Vidal, the painter from the south of France, was introduced to Canada through the gallery. A staircase from a side door leads to the second floor, which is a treasure trove for art lovers.

Hidden away in this area of town are other treasures. Nearby are the coffees and delicious pastries of Van Houtte. Across the road you can browse at leisure in the bookshop of Leméac. There's plenty of reading matter and your hosts don't mind how long you take. Right next door is a florist who features rare plants and a range of African violets. And round the corner on Park Avenue, M. Lalonde has a fantastic assortment of carpets on display in his shop.

Talking of bookshops, you should drop in to Flammarion's at 1243 University Street, near the Place Bonaventure, where you'll find a wide choice of books reasonably priced. The little bookshop in Central Station has an exceptional collection of paperbacks. And the people who live around Côte des Neiges will tell you nothing can beat the bookshop owned by Renaud and Bray (5210 Côte des Neiges) for its wide selection, ultra-modern fittings, and its helpful clerks, who are all booklovers. We should also mention a little shop called Montreal Picture Frame (1076 St. Lawrence) where you can sometimes come up with a real find, since some painters who do excellent work have their paintings on sale here.

There's a small Italian community well worth visiting in the North of Montreal, around the intersection of St-Dominique and Jean-Talon. Its hub is, of course, an excellent Italian restaurant, Bianca and Franco. Inside you'd think you were in Italy. On Sundays you even see long tables set up where at least three generations of an Italian family will gather to celebrate an anniversary or a first communion.

During the week people from all over the city visit this restaurant. It has red and white checkered tablecloths, good wines, more than modest prices; try the delicious escalopes de veau, the soupe aux pois romaine – a meal in itself – or even octopus, if you feel daring. The espresso coffee is black and strong, and cheaper than usual.

Close by is a charming boutique specializing in Italian porcelain. You should also visit Bianca and Franco's bakery – try some "Spanish bread" a fine pastry, straight from the oven. You might also be surprised to see lovely little gifts for sale at the bakery – delicate cups and saucers, vases, and





Montreal as I see it...

Valerie Fournier lives in Ottawa, but often drives to Montreal for a weekend or even an evening with her Swiss husband Pierre, who knows Montreal well. This is her Montreal:

"Mountain Street is *the* street. Close to the heart of Montreal, it fairly throbs with the spirit of the city. Chic boutiques are side by side with discotheques, art shops, and small, intimate restaurants. It's a place to see and be seen, a small world of its own.

"One place we always visit for a real French flavor is Le Bistro. The waiters sport handlebar moustaches and long white aprons as they serve Pernod and sandwiches made with crusty French bread and Camembert. Just up the street is Le Drug, a discotheque which you enter through (!) a crazy metal sculpture.

"Go the other way and you'll find La Guillotine – very dark, with a postage-stamp dance floor and lots of French music. Within a block of Mountain Street is perhaps the craziest disco of them all: the Mousse Spacthèque, where zebra-skin booths, flashing lights, and tailors' dummies are part of the decor. But there are plenty more discos to choose from: Le Crash, the Whiskey-à-Go-Go, Don Juan, and so on.

"Leaving Mountain Street, I love to have a cocktail at the lounge atop the hotel Château-Champlain. Through the huge windows Montreal is sprawled below you, and delicious canapes are served free during the cocktail hour. If you'd rather drink underground, try the several small bars sprinkled through the shopping area of Place Ville-Marie. Each has its own atmosphere; but my favorite is the Club-Car. It really does look like the inside of an overgrown train, and there's lots of popcorn at each table.

"For food, we go to the William Tell (2055 Stanley Street – 288.0139), which makes the best cheese or beef fondue outside of Switzerland while you sit and count the cow-bells. And for the best – and quickest – smoked meat sandwich I've ever tasted go to Dunn's Delicatessen (892 Ste-Catherine Street West – 866.4377). The food is cheap, delicious, and it's open all night! "

brightly-colored bon-bons. An Italian woman with skillfu fingers sits and sews these gifts in tulle; they'll be presented tc ushers or guests at Italian weddings or christenings. Also in thi area you can buy wine in bottles of all sizes and shapes, in thei raffia cradles, or pick up fresh vegetables at a bargain in the market.

History

Much of the history of old Montreal is concerned with the Church. For instance, take the tiny church of Notre-Dame de Bonsecours on St. Paul Street, one of the first churches to be built in Montreal. If you don't suffer from vertigo you can climb up inside the steeple for a panoramic view of the port o Montreal and of the island of Ste-Hélène.

In the basement of this ancient church there's an exhibition depicting the life of Marguerite Bourgeoys, who founded the congregation of Notre-Dame in Canada. The scenes of her life from her childhood in France to her death in New France, are a marvellous reconstruction of the past. The church itself is full o little nuggets of history; you can pick out here and there the names of the pioneering clergy who came to the New World centuries ago, or you can marvel at the workmanship of ages past.

Right at the east end of Sherbrooke Street is a place tha most Montrealers themselves do not know. Called the Chapelle de la Réparation, it's run by the Capucin fathers. In the grounds you will find a copy of the stations of the cross, a peacefu wooded grove, and a baroque-style chapel, where several masses are celebrated on Sundays. There's also a restaurant and an inn with rooms for pilgrims (3650 49th Avenue – 642.5391).

In the heart of Montreal there is a Carmelite monastery situated in a quiet residential street lined with trees (351 Carme Avenue – 271.6957). The grounds of the monastery are peaceful and beautiful, the chapel itself is impressive, and



Far left: She could be in Paris, but Valerie's actually in Le Bistro, on Mountain Street, being served by a waiter clad in the uniform of the house – moustache and long white apron. Be warned – you'll have to practice your French here!

At left: It's not Montmartre, but Place Jacques Cartier in Vieux Montréal, with its flower market and cobbled streets.

Above: Monsieur René, the Corsican maitre d', ducks to avoid the massive flame that illuminates La Barre-500, a restaurant where everything comes flambé.

contains many objects of art. Admittance is from 8.00 a.m. to 10.00 p.m., and vespers are sung each day at 4.30 p.m. from behind the grille.

Sixteen nuns live enclosed in these cloisters. They used to come from all parts of Canada and from the United States, but now are mainly from Montreal. They have designed cards for all occasions that you can buy at a little shop, as well as plaques made out of leather or plastic and mounted on wood or jute.

Flowers and night life

Montreal is filled with parks and gardens, but the one that stands out is the Botanical Garden (4101 Sherbrooke Street East). At the end of June the gardens are a riot of lilacs and peonies and petunias. Above all, you must see the greenhouses with their magnificent permanent collection of exotic and tropical plants. The garden is open in the summer from 9.00 a.m. to sunset and there is a restaurant if you're hungry.

Night-clubs are well advertized in the newspapers, but we'd like to recommend two very different, very French, "boîtes à chanson" that feature good singers. The first is Chez Clairette (1456 Mountain Street – 845.0690), where there are always a couple of singers, and where Clairette herself – whom everyone calls "Mother Superior" – infects the whole audience with joie de vivre. Le Patriote (1474 Ste-Catherine Street East – 522.0626) is equally well-known for the quality of its entertainers, but you should make reservations to be sure of a place, as it's always popular.

And, of course, there are many cinemas and theatres – you'll easily be able to find information on what's playing at such places as La Poudrière, the Rideau-Vert, and the Place des Arts.

Montreal is a fabulous world, wide open for exploration, which you will never quite finish discovering.

Montreal as I see it...

Mlle Eliane Lacroix, translator for the Canadian Nurses' Association, is an Ottawan, New Yorker, Quebecker and Montrealer – in other words, she loves cities. She talks of the Montreal she loves:

"For me, Montreal is the mountain that surveys the city, from where you can see the port, and even Mont-Beloeil and the mountains of Saint-Hilaire and Rougemont. It is the mountain with its footpaths, where it's pleasant to walk on a Sunday morning before it becomes too crowded; the mountain with its Beaver Hill Lake where the children, and sometimes even the grownups, launch their little sailing ships, just as in New York's Central Park or in some of the public gardens in Paris. You'll find many sculptures adorning the park on the mountain; they are a legacy of an international symposium of sculpture organized by Montreal's Mayor Jean Drapeau some years ago.

"Montreal is listening to the open-air summer concerts given on the mountain by the Montreal Symphony Orchestra. There are also concerts in the Maurice Richard arena, where you can listen to your favorite arias sung by local talent, while you eat cheese and sample the wines of the well-stocked cellars of the Hélène de Champlain Restaurant, owned by the City of Montreal.

"Montreal is also the International Festival of Music, which takes place for two weeks each summer. One year this festival is devoted to the piano, the next to the violin, the next to song. And then it's the piano's turn again.

"It is the Dominion Park with its exhibitions of paintings in the open air and its café Guinguette where, in summer, you can sit outside and snack at tables covered with checkered tablecloths.

"It is the Dow Planetarium with its awesome spectacles, the Hôtel-Dieu Hospital founded by Jeanne-Mance, the Montreal Seminary flanked by its two pillars on Sherbrooke Street.

"Montreal is also a visit to the locks of Saint-Lambert de la Voie Maritime, opposite the city, where you can watch ocean-going vessels being lifted up before your eyes and sent on their way to sea." □

Nurses for nursing

Everybody agrees — patients, doctors, administrators, trustees, and particularly nurses themselves: the nurse belongs at the bedside. Nurses must be freed, then, from duties that take them away from the bedside. One new concept — that of ward manager — is being tried at The Hospital for Sick Children, Toronto. It permits head nurses, too, to return to patient care.

Helen Palmer

The hospital head nurse faces a seemingly impossible variety of roles: personnel manager responsible for morale and development of staff under her administration; chief nurse responsible for the overall quantity and quality of care of a number of patients; coordinator of physician-ordered treatments administered by the many members of the medical team; and general arbitrator for everybody's problems. Too often she has no time for her nursing role.

The smooth functioning of the present-day wards depends on the head nurse's administrative ability and physical stamina. She must be the pivotal link in the health team, yet she may be frequently interrupted in her duties. One study of head nurse activities showed that she is interrupted an average of once every 30 seconds to answer innumerable questions and solve the problems that arise on an active ward.

A few years ago, the Massachusetts General Hospital tried to solve the problem by delegating non-nursing ward administrative functions to a unit manager; this freed the head nurse for her primary function – care of the patient.

The concept of the unit manager is based on the recognition that the hospital functions smoothly with a separation of administrative and medical functions. The hospital administrator coordinates the functions of the hospital and allows medical personnel to concentrate on their primary function – care of the sick. This system has worked well. The assumption, then, is that a ward would benefit in a like manner by extending management into the ward system, thus relieving the head nurse of her non-nursing functions.

The validity of such a plan was tested at The Hospital for Sick Children, Toronto, as a pilot project October 1966 to October 1967.

Pilot project carefully planned

The experimental project for a ward manager system was set up and implemented by the medical nursing department. The project itself was tried with one ward manager for two adjacent wards during the day for eight hours, five days a week. The ward manager was directly responsible to the hospital's coordinator of medical nursing.

The ward manager worked as a partner with each of the two head nurses. It was important in the beginning that she cooperate with departments such as pharmacy, diet kitchen, and laboratory. The housekeeping department, being autonomous, allowed the ward manager no direct control over housekeeping staff within the two wards; cooperation, however, was excellent.

A job description outlined the main functions and suggested a way to categorize duties: managerial and nursing. The managerial duties were described in more detail than were nursing duties. The analysis attempted only to show how to avoid overlapping.

The ward manager was responsible for nursing aides and clerical personnel. At The Hospital for Sick Children, the nursing aide is a non-professional worker, who is trained on the job and who carries out selected routine duties under the direction of the ward manager. *She does not give direct patient care.*

The duties of the ward manager were:

- To cooperate with the head nurse and her staff in providing a clean, tidy, pleasant environment as economically as possible.
- To handle the budget for the floor and to consider carefully all expenditures.
- To maintain all ward supplies, equipment, and furnishings and to supervise their use.
- To coordinate the departments of housekeeping, pharmacy, diet kitchen, laboratory, and x-ray to facilitate good patient care.

The qualifications of the ward manager are important because she must be able to adapt to and cooperate with the head nurse. She must be intelligent, have above average initiative, and be able to organize. She must be firm courteous,

Miss Palmer is Co-ordinator of the Medical Nursing Department of The Hospital for Sick Children, Toronto. This article is based on the official report of research into the use of a ward manager at that hospital.

pleasant, consistent, and skilful in communicating with people. Previous training or experience in management skills is a valuable asset. Whether the ward manager is a man or woman seems unimportant. The salary for a ward manager probably should be on a par with that of the head nurse.

A threat to the nurse?

The person most affected by the ward manager system is the head nurse. She loses many of her daily routine duties and is required to change the emphasis in her functions.

In the past, her administrative role has tended to take precedence over patient care and personnel supervision. Although the responsibility of housekeeping and clerical duties has to some extent been taken over by auxiliary staff, the head nurse was still left with so many administrative duties that her position was frequently dubbed "nursing the desk" rather than "nursing the patient."

A curious status has been attached to "nursing the desk." Nurses were rewarded for managerial functions so they naturally gravitated toward this role.

Reorientation of responsibility may prove difficult during the transition period. Obviously, duties and responsibilities of both head nurse and ward manager need to be carefully defined so that the head nurse does not feel that the loss of desk responsibilities has lowered her prestige and status. She must clarify her position in her own mind. Rather than dissipate her newly found time on such minor duties as transporting a patient to x-ray, delivering specimens to laboratories, or making empty patient beds, the head nurse must use the time she gains by planning and directing the *nursing* functions of her ward.

In establishing this system in The Hospital for Sick Children, the head nurse was asked first of all to differentiate between the functions related to nursing and the purely administrative ones. In this way she became involved in assessing her own role as a nurse. Because she was now able to concentrate on this aspect of her job, she began to see the possibilities for improved patient care.

In the pilot project, fortunately, both head nurses believed in nursing; both welcomed the opportunity to become involved in improving team nursing, to promote better team conferences, and to develop nursing care plans that would provide individualized, personalized, and coordinated care.

Involvement of all staff

The coordinator of medical nursing held meetings with unit staff to interpret the ward manager system and to give the nursing staff an opportunity to express their feelings. Throughout the entire planning stages, nursing staff expressed ambivalence; although they looked forward to the change, many nurses doubted the feasibility of the project. Most nurses regretted that there had not been more time in the past to concentrate on quality nursing care and on the smooth operation of the nursing teams on the floor; if the ward manager system met these needs, then it would be welcome. It was understood from the beginning that the role of the assistant head nurse would become redundant with the new program

Before the system was begun, it was absolutely essential that interpretative sessions be held for all department heads with whom the ward manager would be in direct liaison in her managerial functions. Memoranda were sent to other departments informing them of the new experiment and requesting appointments to discuss it. In this way the ward manager could personally meet each department head; all displayed interest and enthusiasm.

The medical physician-in-chief presented the project to the medical staff as a group and enlisted their support for the study. More detailed discussion was held individually with the physicians responsible for the floor involved in the experiment.

A resource manual was prepared; it included the outline of projected duties of the ward manager, the ward clerks, and the nursing aides, and a copy of all available literature on ward manager programs. Quotas were established for central supply room supplies, and surgical and stationery supplies. Changes were made in the handling of linen supplies, and in the set-up of utility rooms, nursing station, and head nurse's office.

Problems of transition

In the beginning, daily conferences were held for the ward manager, the head nurses, and the coordinator. After the program was underway, conferences were held weekly. Eventually, conferences were called only as necessary. Short daily sessions between the head nurses and the ward manager maintained the program.

Doctors as well as nursing staff were affected by the introduction of the ward manager. The doctor was required to relate to two people, the head nurse and the ward manager. For this reason, some hospitals have placed the ward manager under the supervision of the head nurse; other hospitals have made them equal.

Medical staff had suggested that the scheme might produce a two-boss ward if they were made equal, but it was decided that only if the head nurse was completely relieved of responsibility for non-nursing functions would she in the final analysis be allowed to carry out her real function – nursing. The ward manager was, therefore, placed in partnership with the head nurse. If there were conflict, it was clearly understood that any final decision affecting the patient in any way was to be left to the head nurse.

It would be unrealistic not to acknowledge that there were problems during the transition period. Probably the most acute problem related to doctor's orders – *a point of communication regarding the patient.* It was difficult for the head nurse to adjust to the fact that the responsibility for transcribing doctors' orders now came under ward management; the nurse's function was now to review, to interpret, to implement, and to follow through.

A lesser problem presented itself when the ward manager was ill or on vacation and her activities were taken over by the nursing staff. On the other hand, when the ward clerk was ill or on vacation, the ward manager picked up the clerical duties. Before the ward manager system came into being, the head nurse routinely filled all gaps.

Immediate results

Results of our pilot project have been encouraging. We have proven that many non-nursing activities, which had originally occupied too much of the head nurse's time, can be successfully transferred to the ward manager. There are many examples:

- The ward manager now supervises the use of laundry and adjusts the quotas.
- Before the advent of the ward manager, the head nurse often delegated the ordering of pharmacy supplies to one of the nurses; her supervision, however, was frequently necessary to ensure adequate but not overstocked supplies.
- The laboratory departments are now so extensive that in the past as much as *one hour* of the head nurse's time has been required to trace the particular laboratory specializing in a certain test and then arrange for the test to be done. Now the ward manager finds the correct laboratory, books the test, and follows through by seeing that the specimen reaches the correct laboratory, and finally by filing the results in the patient's chart.
- Strictly clerical work involving booking of x-rays or operations was extensive and time-consuming, often requiring more than one phone call. The ward manager now arranges bookings, records them in a book, and checks them off as they are completed. This provides a fast check for both doctors and nurses.
- All maintenance repairs, such as requests for the repair of blinds, curtains, plumbing, or lights had to be channelled through the head nurse. Now the ward manager routinely checks all such items and requests repairs when necessary.
- Although items from central supply are used only by nursing personnel, it does not require nursing skill to order them; a specific quota exists and no judgment under ordinary circumstances is required to order them These supplies are now maintained by the ward manager.
- The supervision of the work of ward clerks and nursing aides, although it was housekeeping and clerical and not nursing, was time-consuming. Supervision is necessary, however, if these people are to work at full capacity. The head nurse was not always available to provide this essential supervision. This, also, is now the responsibility of the ward manager.



The unit manager works closely with the head nurse on the unit.

The head nurse, relieved of these onerous tasks, is better able to concentrate on her primary duty of planning and supervising nursing care. This may best be illustrated by the following examples.

First, the greater part of nursing care requiring supervision is done in the morning. The preparation of patients for tests medications, treatments, and genera organization that sets the tone of the day is done in the first two to three hours of the day. This had been the time of day when the head nurse found herself checking pharmacy, supplies, and supervising clerical work. Now, this time of day is relatively free for her to supervise nursing care.

Second, all calls are screened by the ward manager during doctors' rounds and interruptions are kept to a minimum This allows the head nurse to give undivided attention to the discussion o plans for the care of patients as outlined by the doctor.

Third, rather than spending time stamping requisitions, making bookings

and transcribing orders, the head nurse needs only to oversee the orders. The remaining time is spent in supervising the nursing care required by the new orders.

Fourth, patients and parents have come to know the head nurse as a person, a factor that has increased their confidence in the nursing care. The head nurse now has time to keep both the patient and his relatives informed about his condition. The psychological benefits of this rapport cannot really be estimated.

Fifth, the head nurse can now leave her ward for meetings with the knowledge that the general staff nurse left in charge would not become overladen with paperwork. She is free to supervise patient care; the ward manager is available for all other activities, and the organization of the ward does not disintegrate.

The results also have been shown in improved team nursing, better team conferences, and the development of a plan for personalized care. Nurses participating in the pilot project have shown approval.

Many doctors have said that they have gained from the ward manager system. They have the undivided attention of a head nurse uninterrupted now by routine matters of ward administration.

Another group who believed they profited were those who supplied the auxiliary services. Their association with the ward was made more efficient because all communication was now channelled through one person, the ward manager.

Long-term results

It is hard to evaluate quality nursing care objectively. We would like to be able to say the nurses did spend the time gained in improved patient care. However, in physical care, such as bed baths, intravenous administration, and medication, little change was noticed. The emotional, social, and mental needs of the children, however, were much better met.

In addition, the nursing care plan improved the services of the occupational therapist, the physiotherapist, the medical social worker, the school teacher, the nursery school personnel, and the public health nurse. Prior to the project, full use had never been made of the facilities they offered. For instance, the school teacher had in the past often identified an individual child's problem, but no team meetings were arranged routinely for discussion. This lack of communication precluded comprehensive nursing care, so vital to the child's recovery, psychologically as well as physically.

At the end of the year's experiment, the nursing department concluded that the project justified its extension into all wards. It is being introduced in stages. At present the ward manager system is autonomous within nursing, under the direction of an administrative assistant of the hospital who is responsible to the director of nursing.

Perhaps not for all

The ward manager system is not necessarily suited to all hospitals or all hospital situations. For instance, the Frieson type of hospital with a built-in system for keeping the wards supplied with everything needed for patient care probably would not benefit from this system, nor would a small hospital unsuited to unit operation.

Within a single hospital, all areas might not benefit equally from the ward manager system. The type of care required and the size of the ward involved are factors to be considered. Economics is also a factor. At The Hospital for Sick Children, it was found that one ward manager can handle two wards, obviously a financial saving.

This is a changing world in a computer age. We must be aware of the weaknesses in our particular hospital system, the necessity of continually reexamining and reassessing methods of delivering nursing care. We must take steps toward constructive change. What was satisfactory and perhaps efficient 20 years ago may not be so today. It behooves us, as nurses, to be aware of modern trends, of possible improvements not only in nursing techniques but also in ward management.

To predict the continuing success of this program is difficult. Problems such as staff turnover have not been solved. Like all other systems, success or failure depends on the enthusiasm or lack of it shown by the people involved. Resistance to change is one of the major hurdles to be overcome. Continuing education is needed to make this transition easier and more effective. The head nurse who is thoughtfully involved in nursing takes advantage of her new found time to stimulate nurses to return to nursing that focuses on the patient and his needs. The ultimate success of the ward manager system lies in the creating of a balance of trust between the head nurse and the ward manager.

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Cytology screening — a program that works

In 1949, an intensive campaign to detect early cases of carcinoma of the cervix was begun in British Columbia. That province now has the lowest incidence of invasive carcinoma of the cervix in the world. This article will help nurses to be well-informed about the value of screening programs so that they can help to reduce further the incidence of cervical cancer.

Margaret A. MacLean, B.N.

Cancer of the cervix has a long latent period; it may take 10 to 15 years to progress from the pre-invasive stage of carcinoma to the clinical disease of invasive carcinoma of the cervix. Statistics indicate the average age of onset of cervical cancer – as carcinoma in situ – is 37.7 years. The average age of all cases found with in situ carcinoma is 42.3 years; microscopic invasion of cervical tissue, found between onset of in situ and the invasive stage is at 46.2 years; the occult stage of invasive carcinoma is found in women at 49 years; and the clinical invasive stage is 52.1 years. This indicates an average 15-year difference between onset and clinical disease.

A free cytology screening program aimed at early detection and control of cancer of the cervix was begun in British Columbia in 1949. BC now has the lowest incidence of invasive carcinoma of the cervix in the world.

The theory was that in situ carcinoma of the cervix is a precursor of invasive carcinoma and that its removal would result in a significant lowering of morbidity and mortality from carcinoma of the cervix. [1]

During the early years, growth of the program was slow; by 1955 only 3 percent of the population had been screened. Since then, the program has expanded steadily. By the end of 1966, approximately 75 percent of all women 20 years of age and over, within the province, had been tested at least once for carcinoma of the cervix. At present (Dec. 1968), approximately 1,300 smears arrive in the clinic daily.

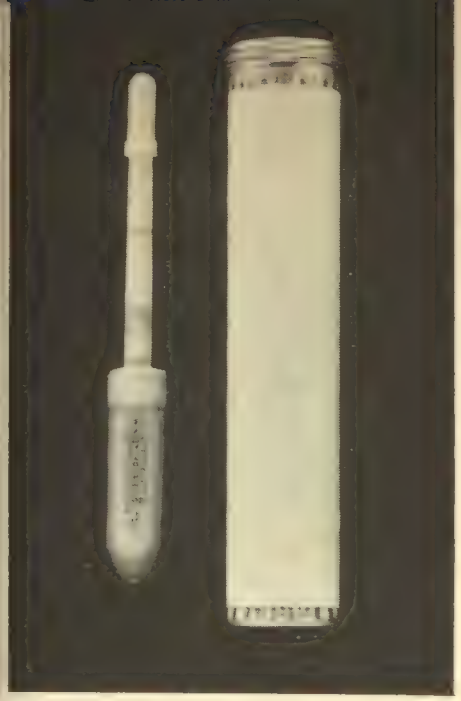
Screening procedure

Most specimens to be examined are "Pap" (Papanicolaou) smears. These are prepared by scraping cells from the cervix, placing the scrapings on two glass slides, and fixing the smear with an aerosol, water-soluble fixative *(Figure 1)*. The slides are then sent to the Central Cytology Laboratory of The Vancouver General Hospital and The British Columbia Cancer Institute for processing and interpretation. Ninety percent of specimens are submitted by private doctors.

The slides are examined and a notification is sent back to the doctor. The classification is:

Class I :showing normal cells.
Class II : shows some atypical or inflammatory cells.
Class III: shows suspicion of malignant change.

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This photograph shows the Cytette, a cytological specimen collection pipette, capped, ready for insertion into the mailing container. The Cytette is a method of collecting cells from the vagina and cervix – a technique that can be carried out by the patient at home.

TABLE I
Incidence of Clinical Invasive Squamous Carcinoma of Cervix in Women Over age 20

Year	Population in Thousands	Clinical Invasive Carcinoma	
		Total Cases	Incidence
1955	422.9	120	28.4
1956	436.7	119	27.2
1957	460.9	120	26.0
1958	473.0	112	23.7
1959	478.8	108	22.6
1960	486.4	96	19.7
1961	496.0	115	23.2
1962	503.0	78	15.5
1963	513.0	98	19.1
1964	526.8	86	16.3
1965	543.2	80	14.7
1966	566.5	77	13.6

Correct at Jan. 1968.

Class IV: shows malignant cells.
Class V : is conclusive for malignant cells.

Classes I and II require no further investigation. Class III calls for a repeat cytology smear. Should the repeat smear verify the first report, then a cone biopsy is recommended. Classes IV and V call for investigation – either a cone biopsy or a punch biopsy – and treatment.

Cone biopsy is diagnostic, but in early stages may also be sufficient treatment as well. In a cone biopsy, a cone shaped section of the cervix is removed *(Figure 2).* Examination of sections (microscopic) of the cone biopsy indicates whether the lesion is on the surface (pre-invasive) or has penetrated the surface (invasive). Complete examination of the sections will provide a map giving an accurate picture of the extent of the lesion.

When the disease penetrates beyond the vaginal portion covered with squamous epithelium, it is no longer pre-invasive or in situ carcinoma. At this stage, the cone biopsy is not only a diagnostic measure but also a surgical cure.

Records obtained from cytology smears and cone biopsies are kept on case cards in the Cytology Department of The British Columbia Cancer Institute. Each subsequent examination is recorded. There, a complete follow-up is carried out on each case. There is correlation between cytology and tissue diagnosis as all biopsy and surgical specimen reports are reviewed.

Source sheets detailing the age and cytological history have been made out on all cases since 1958. These are submitted to the Provincial Division of Vital Statistics for collation of population screening data. The data from all positive cases are kept on punch cards in the statistical research department and evaluated separately and in more detail.

It is most important that the private doctor is responsible for a follow-up on these cases. A letter is written by the cytologist to the patient's doctor requesting an annual repeat examination on those who have positive cytology. If smears are not received by the date requested, two subsequent letters are sent at two-monthly intervals. If there is still no response, the public health nurse contacts the patient directly to ask her to go to her doctor for a repeat cytology smear.

All new cases of invasive carcinoma have been kept in a separate registry since 1955. This register is compiled from province-wide lists submitted by the Division of Vital Statistics, as cancer is, by law, a reportable disease. These lists are obtained from all pathologists in the province who diagnose carcinoma of the cervix by biopsy or autopsy and also from lists from the treatment centers. By these means, recurrent disease, errors in notification, name changes and other causes of duplication can be detected.

Effects of program

These registries provide a reasonably reliable annual incidence rate for invasive carcinoma. This is important as the incidence rate is the first that one might expect to be affected by the screening program *(Table 1).*

In 1965, an article of mine reported that the drop was from 28.4 cases per 100,000 in 1955 to 15.5 cases per 100,000 in 1962 – a drop of 45.5 percent in seven years. I called it "statistically significant" then. [2]

The incidence rate has now dropped to 13.6 per 100,000, or 48 percent of the basic rate in 1955!

The second or the ultimate goal is a reduction in the mortality rate. In the last four years, there has been a drop, which, if maintained, will be significant *(Table* II.

A more effective way of measuring the results of a screening program is to compare the annual incidence of invasive disease in the segment of population that has been screened with the unscreened segment *(Table III).* These figures indicate that the numbers of women developing invasive carcinoma of the cervix are six to seven times greater among those who have not had screening tests done.

Table III also shows that the population previously screened is generating

TABLE II
Crude and Refined Mortality Rates for Squamous Carcinoma of the Cervix in the Province of British Columbia

Year	Population in Thousands over Age 20	CRUDE No. of Deaths	CRUDE Rate 1/100,000	REFINED No. of Deaths	REFINED Rate 1/100,000
1958	473.0	65	13.5	54	11.4
1959	478.8	65	13.6	51	10.6
1960	486.4	50	10.3	48	9.9
1961	496.0	66	13.3	51	10.25
1962	503.0	81	16.1	65	12.9
1963	513.0	60	11.7	57	11.0
1964	526.8	65	12.3	56	10.6
1965	543.2	56	10.3	42	7.7
1966	566.5	66	11.7	44	7.8
1967	592.4	52	8.8	38	6.4

Correct as at June, 1968.
CRUDE rate—from the Division of Vital Statistics.
REFINED rate—each case is reviewed and evaluated by the Cytologist. He has investigated to determine if the cause of death was carcinoma of the cervix. The reports, both hospital records and the B.C.C.I. records are thoroughly investigated. There have been cases where the original diagnoses were not carcinoma of the cervix. The B.C.C.I. Registry has been kept since 1950.

new disease at a rate of about 4.5 per 100,000 whereas the rate in the unscreened population is about 29 per 100,000 which is very close to the basic incidence rate in 1955.

Cases were detected at an earlier clinical stage in the screened than in the unscreened and also the mortality rate is less. At present, it is 22 percent compared to 39 percent.

One important fact is that, as a result of the screening program, 3,667 cases of pre-clinical squamous carcinoma of the cervix have been detected that would *not* have been detected without a screening program as they were found mainly by cone biopsies on *clinically negative* but *cytologically positive* cervixes.

Some problems encountered

The cytology program, to be effective, must involve all women in the area. This is always difficult in any large-scale, voluntary-population study, when the participation depends, in part, on the socio-economic and educational levels in the community.

In one study on the British Columbia program it was found that the better educated and informed women were the ones being reached. [3] The woman who takes advantage of a screening program is the same one who would present herself to the doctor with very early symptoms of the clinical disease. Conversely, the woman who would ignore symptoms as long as possible (hoping they would go away), would also ignore the screening program. For this reason the nurse, as a community health teacher, must use every opportunity to reach and teach all women. To be effective, the nurse herself must be very well informed.

Only about 75 percent of the female population in British Columbia has been reached; the aim is to reach all women.

Cytology is not a perfect diagnostic tool; it is estimated that there is at least a 10 percent false negative error. Because of the spectrum of this disease there is a difficult zone of atypicality between dysplasia and in situ carcinoma which is reflected in cytology, so it is often impossible to know when in situ carcinoma actually begins. Also, smears can be badly taken and miss the disease.

New developments

The screening program so far has depended mainly on the results of only the Papanicolaou smear taken by the doctor during a vaginal examination. Currently there is another method (still unknown and somewhat controversial) being introduced to obtain cells. In this test, a "Cytette" is used. The Cytette is a cytological specimen collection pipette containing 6 cc. of pink, isotonic, cytological irrigation solution, which also fixes the cells until they can be examined.

This method is carried out by the patient at home, and there is no need for a vaginal examination procedure in the doctor's office. The patient is told to obtain the specimen at least one week after menstruation, and to avoid douching or sexual intercourse for 24 hours prior to obtaining the specimen. She is instructed to obtain cells by inserting the stem of the Cytette into the vagina, squeezing the bulb, and injecting the solution into the vagina. Then, by moving the bulb from side to side and releasing the pressure on the bulb, the solution can be aspirated back into the bulb. It is very important that almost all solution is collected back into the Cytette. When it is removed from the vagina, the solution in the bulb will now appear yellow (or amber) in color. The cap is replaced firmly and the Cytette is returned to the mailing container with the completed requisition and mailed, as quickly as possible, to the Cytology Laboratory.

This procedure may be one way to obtain specimens from those women we are not reaching. The specimen can now be obtained in the privacy of the woman's home without visiting the doctor and at no cost to the patient. At present we do not know how valid this method is. The majority of physicians I have talked to believe it will not replace the cytology smear, which is definitely considered the method of choice.

One can envision the advantages of a "well-lady" Cytology Clinic staffed by nurses where "follow-up" could be done. Some of the advantages might be that it would relieve the pressure in the doctor's office and be less time-consuming for the patient. This way, a small segment of the population who will not see a doctor might be reached.

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TABLE III

Incidence of Clinical Squamous Carcinoma of Cervix in Women over age 20—Screened and Unscreened Segments of Population

Year	Those screened to previous year (in 1,000s)	Clinical Invasive Carcinoma Cases	Rate per 100,000	Those unscreened to previous year (in 1,000s)	Clinical Invasive Carcinoma Cases	Rate per 100,000
1961	120.9	5	4.14	375.1	110	29.33
1962	164.2	7	4.26	338.8	71	20.96
1963	214.9	10	4.65	298.4	88	29.52
1964	260.0	12	4.6	266.8	74	27.8
1965	310.0	13	4.2	233.2	67	28.8
1966	357.0	17	4.8	209.5	60	28.6

Correct Dec. 1967.

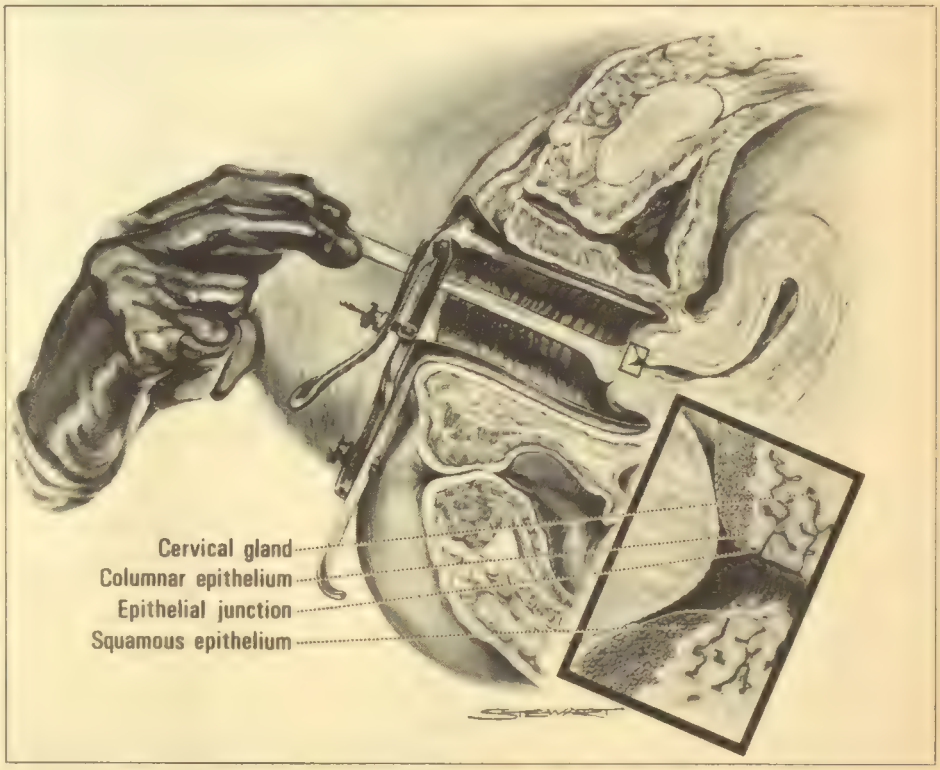


Figure 1.– The diagram shows the Ayre's (or Papanicolaou) spatula in position for removing cells from the most vulnerable part of the cervix, the squamous-columnar junction.

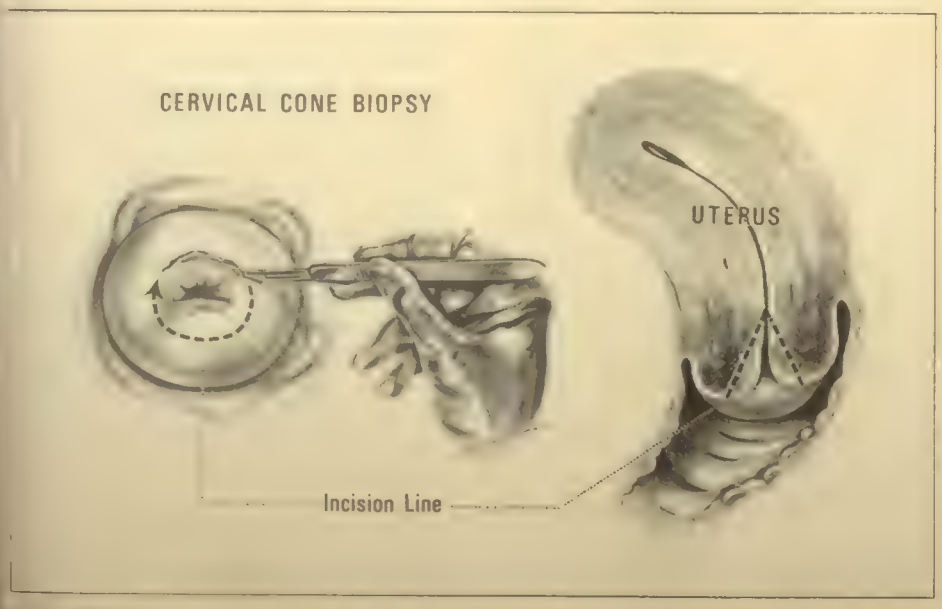


Figure 2.– In a cone biopsy, the point of the cone is directed toward the internal os but does not include it. The biopsy leaves the cervix intact and does not usually interfere with the potential for pregnancy and normal delivery. □

Psychodrama

Description of a form of group therapy that permits patients to work out feelings and conflicts through the medium of spontaneous drama.

Dorothy M. Burwell, Reg.N., M.A.

Two persons, a man and a woman, are on stage. The lights are dim. At first, the man speaks to the woman in subdued tones, as though he is afraid of revealing his true feelings. Then, gradually, his voice becomes louder as he forgets his audience and directs his anger toward the woman. His voice subsides again. He begins to sob openly. Later, he will try to describe his feelings and reactions to his "audience." Now, he just weeps.

This "actor," who was reenacting a scene that in actual life had been disturbing to him, is one of many persons presently being helped by psychodrama – a group psychotherapeutic technique that encourages individuals to act out their conflicts in life situations. In this "play," the person portrays himself, and, in the medium of the group, reveals and shares his feelings of anger, fear, and frustration.

Psychodrama was brought to North America by a Viennese-trained psychiatrist, Dr. J.L. Moreno, in the 1930s. As a young medical student in Vienna, Dr. Moreno had been impressed by the spontaneity of plays enacted by children. Later, while studying psychiatry, he began to realize that the play medium could be used to help patients resolve their problems. Today, Dr. Moreno has two centers in the United States where psychiatrists, nurses, psychologists, social workers, and clergymen meet to study group psychotherapy and psychodrama.

In Canada, at least two centers use psychodrama as a form of therapy. At the Clarke Institute of Psychiatry in Toronto, psychodrama is used as an adjunct to individual psychotherapy. Only patients who have been referred by a psychiatrist take part in the group.

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Spontaneity of action

Two major problems of patients with psychiatric disorders are: a lack of inner spontaneity and creativity in behavior, and a break in human relationships with significant others – family, friends, and co-workers. In the medium of the group, with spontaneity as the key, the patient's feelings begin to emerge. All his anger, frustrations, fears, longings, loneliness, and confusion are shared with the group.

In psychodrama, the patient reenacts scenes that have bothered him. The group is kept small – 10 to 12 persons – and intimate. The therapist acts as the director of the drama. At the Clarke, the only director is a registered nurse. The patient who reenacts the scenes (usually only one person is selected for each meeting) is the "protagonist" for the meeting.



The director of the psychodrama session, Dorothy Burwell (second from left), interviews the protagonist "Mary," while the group listen attentively. For this photo, staff members posed as patients.

In a typical session, the director has a short interview with the protagonist; then the lights are lowered. The director might say, "Show us what happened, Bill. Where did it take place? What was the room like? Where are the windows, where is the television set? Where are the chairs, the couch? Where were you sitting? Where was your wife sitting? Who started the argument, and how was it started? "

To reenact the scene, other members of the group are drawn into the action as significant others" in the life of Bill to represent mother, father, wife, and children. These members are called the "auxiliary egos" (*not* alter egos). As the scene unfolds, Bill may not feel free enough to express his thoughts or innermost feelings. We then have a staff member or another patient play the role of the "double."

The double moves and acts as Bill does, expressing what he (or she) thinks Bill would like to say but cannot. Bill does not have to agree with his double; he may even turn and have an angry encounter with him. The double supports the protagonist as he expresses his inner world to the group, acts as a catalyst, and encourages the protagonist to bring out his feelings of anger, fear, or warmth, joy, and love.

Several scenes that have bothered Bill are reenacted in one meeting. In the final scene, or "closure," the director helps the protagonist and the group to experience positive feelings. These positive feelings will give the protagonist courage to try new patterns of behavior to help release his fears, anxieties, and frustations, and to cope with life's crises. Thus, the director might ask Bill to replay a scene as Bill would like to see it happen if the same circumstances were to occur in the future.

The lights are then raised, and a discussion on "how we can support and help Bill," follows. At this time, patients relate similar experiences they have encountered, or offer suggestions on ways Bill could handle the situation in future.

Two techniques used

Two techniques used within the drama are the "soliloquy" and "role reversal." The soliloquy finds the protagonist moving slowly around the room with his double, speaking about his feelings as he approaches the scene. For example, Bill is on his way home. He speaks aloud: "How do I feel, as I come closer to the time when I shall meet the barrage of anger that my wife no doubt will have ready for me? "

The role reversal usually takes place during a scene where there is a significant encounter that indicates lack of understanding on Bill's part. The director then would say, "Bill, reverse roles with your wife. For a few minutes you sit where she is sitting, and the auxiliary ego playing her part will sit where you are sitting." Then the director might ask, "Now, Mary [Bill's wife], what do you think about Bill? Do you love him? "

At this point, Bill must try to see himself through his wife's eyes. As a consequence, he may begin to understand his wife's feelings.

Often a husband and wife are in the same group, each playing his or her own role. In this event the "masks" come down – the real person within him meets the real person within her, perhaps for the first time. And the "I-Thou relationship," as Martin Buber calls it, is strengthened.

Lighting effects can be helpful. People who are sensitive to color respond better when blues and greens are used for the sad scenes, and when a rosy glow is cast over the group for the more joyful scenes. The lights are lowered as the drama begins and often are not raised again until the discussion starts. Tears are expressed more openly in the darkened room, and those who are self-conscious or anxious are more relaxed when not seen so openly.

Value of psychodrama

A study I conducted recently with one of the psychiatrists from a neighboring Ontario Hospital and with two groups at Clarke Institute of Psychiatry, reveal several positive effects of psychodrama.



The protagonist, "Mary," and the double, standing behind her, reenact a scene that in actual life had disturbed Mary. For this photo staff members posed as patients.

1. The drama has an abreactive effect (a means of opening up and expressing feelings) that often continues for the day. Frequently, the patient's "frozen anger" is melted by this acting out process, and the patient responds better to his psychotherapy. Other members of the group also experience this abreactive effect as they listen to another person's story, which may "hit home."

2. Communication is enhanced, not only between patients and staff, but also among patients – who become more open with each other – and among staff members.

3. Staff begin to understand the patient better as he expresses his inner feelings, and attitudes often change. For example, the manipulative patient may no longer be regarded as an uncooperative patient, but as a person who has underlying fears of rejection and loss, who must continually test staff relationships.

4. Psychodrama offers a way of relieving anxiety within patients. Even the most psychotic patient can often be reached if a staff member assumes the role of the "double," and helps him to express his thoughts and feelings.

5. A closely knit group is developed more quickly than with other kinds of group therapy. The action helps patients to talk, and the tele, or the reaching out to others, helps to cement the group. The result is more than group cohesiveness; it seems that a deeper feeling, as within a family, exists. Many patients have said, "This is the first time that I have ever felt an important part of a family."

6. A reintegration of personality begins. During one role reversal, patients played "staff" and staff played "patients." A patient who had required considerable persuasion from staff to attend the workshop rose slowly to her feet as the session began. Pointing to the nurse, she said, "*You* go to the workshop today. I'm boss here just now." That afternoon the same regressed patient – now with a new feeling about the workshop – put on her best clothes, made up her face, and, without any further assistance or encouragement, went to the occupational therapy bazaar and had a wonderful time selling things to patients and staff.

7. Psychodrama teaches patients new ways of coping with their panic. One boy, Joe, trembled and perspired, his fist clenched, while he watched a drama unfold. I went to him, touched him lightly, and quietly suggested, "Joe, you are frightened. Take three deep breaths, relax, and drop your anger." He did, and immediately burst into tears. The next week, Joe stopped a scrap on the ward by going between the boys and telling them to take deep breaths, relax, and drop their anger – which they did. The outburst stopped, everyone laughed. Frank, who was involved in the fracas, claimed that Joe had hypnotized the two, "just as Mrs. Burwash had done."*

*"Burwash" (the farm belonging to the Ontario Department of Reform Institutions), has become Mrs. Burwell's nickname on the Forensic Unit at the Clarke Institute.

Summary

Psychodrama has proved to be a successful supplement to the one-to-one relationship that the patient has with his psychiatrist. In portraying himself, the patient has a "second chance" to relive and reenact situations in his life that have been disturbing to him. As part of a group, the patient is able to discuss and examine his reactions and ways of coping with stressful situations. In most instances, both the patient and his "audience" benefit from this acting out of repressed feelings.

With psychodrama, the patient's psychotherapy progresses much better. In addition, the patient begins to be enriched by his encounters with others in the group, and may even feel that this group has become similar to a new family. Often, psychodrama helps to stimulate and reawaken the patient's spontaneity and creativity as he relives his unpleasant experiences.

Finally, I have found this to be one of the best techniques for changing staff attitudes toward patients, patients toward patients, and patients toward staff. Now we become real to each other, as we see through the eyes of the other and sense the inner world of the other. The staff meeting following each session is particularly helpful, as the staff, too, become involved and feelings are shared. And learning in psychiatry cannot take place without involvement. □

The amputee and immediate prosthesis

Postoperative fitting of a prosthesis, early ambulation, and weight-bearing allow a patient with a below-knee amputation to walk with relative ease.

M. Shewchuk, B.Sc.N., and Z. Young

Until recently, many patients with amputation of the lower extremity have had to wait from three to five months for stump shrinkage before being fitted for a prosthesis. As a result of this immobility of the stump, muscle weakness, joint contractures, and soft tissue wasting have occurred, often preventing the patient from wearing a lower extremity prosthesis.

In the past, this problem has been particularly true for persons in the older age group, who are prone to conditions such as peripheral vascular disease and gangrene, which may require lower limb amputation. Too often, because of loss of functional use of the leg stump, these elderly persons have been unable to wear a prosthesis. Many today are confined to crutches or wheelchairs for the remainder of their lives.

Recent developments

During the past decade, much research and experimentation have been focused on the patient with a lower limb amputation, bringing to light the need for earlier ambulation and progressive weight bearing. It has been found, too, that in the past, legs were amputated above the knee with little consideration given to the function of the stump. The need for saving and retaining use of the knee joint and muscles at the site of amputation has only recently been recognized by all surgeons.

Departments of physical medicine and rehabilitation, prosthetists, and intensive physical therapy programs in large, well-equipped hospitals have developed new and extremely valuable programs to prepare the stump for functional prosthesis; the objective is to train the amputee for an optimal gait after fitting him with a prosthesis. As a result of advances in prosthetics and amputee training, immediate fitting of a temporary prosthesis following amputation has been started. This procedure may be carried out at a number of different anatomical levels; however, this article will deal essentially with below-knee amputations.

Preoperative care

All patients who are to have amputation should be advised by the surgeon of their chance for prosthetic replacement. Psychological preparation of the patient who will be fitted immediately after surgery remains essentially the same as for conventional forms of amputation. However, if the patient realizes that he will ambulate with a prosthesis the first day after surgery and will have considerable independence, he is more reassured and comforted than if he were faced with a long waiting period.

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Patient standing on scales to determine poundage of weight-bearing.



Patient wearing plaster socket with adjustable wedge-disc unit and Sach foot attached.

The therapist or prosthetist visits the patient at least one day before the operation to explain the rehabilitative treatment plan. He teaches the patient the required active range of motion, with emphasis on exercises for the hip and knee on both sides.

The prosthetist measures the patient's leg length and calf circumference to determine the most suitable size of Knit-Rite* stump sock. The patient's shoe is fitted with a Sach foot (a soft, cushion-like prosthesis). A one-half inch lift is glued to the heel to obtain more accurate alignment to compensate for the temporary absence of a shoe. An adjustable prosthesis is assembled, consisting of a one and three-quarter inch aluminum tube with an adjustable wedge-disc unit on both ends ready to incorporate into the cast (socket) immediately after surgery.

Operative procedure

After the limb is amputated below the knee, the surgeon performs a myodesis, suturing the fascia and muscles to distal bone stumps with fixation through drill holes. Special surgical flaps for surgical closure have been developed to enhance the success of the procedure. A one-half inch rubber drain is left in the suture line to prevent pooling under the skin flaps. The drain is not secured as it is removed within 48 hours through a small cast window.

A thin, non-adherent dressing and a layer of fluffed 4" x 8" gauze cover the wound, followed by the stump sock. Commercially-prepared, tapered, one-quarter inch felt pads are secured to the stump over sensitive areas and bony prominences, such as patella, head of fibula, anterior tibia, and lateral femoral condyle.

A specially prepared elastic plaster Orthoflex** – which has the tension of a top quality elastic bandage, is applied and allowed to set. Care is taken to allow at least 5° flexion in the knee joint so that a near normal position for walking is retained. The previously prepared flanged upper component prosthesis is attached to the socket and secured with plaster. A buckle is also incorporated into the cast to be secured to the waist belt to prevent slippage. Under the care of qualified personnel, the patient obtains "total contact" of the stump immediately following surgery. "Total contact" means that the total area of the stump receives a certain degree of pressure that is kept up continuously. This pressure helps to decrease phantom pain.

Postoperative care

Vital signs are observed for any evidence of shock and blood loss. Considerable bleeding may occur before it becomes visible on the cast. Excessive edema is reported immediately as it may result in tissue damage or circulatory impairment; extreme pain may be evidence of edema. The cast must remain secure; if it comes off, the limb is wrapped immediately with an elastic bandage and a new cast is applied. No attempt is made to replace the old cast.

First postoperative day

On the morning of the first postoperative day, the patient is taught to stand at the bedside in a secure walker, "feathering weight" only. This means he rests the weight of the prosthesis on the floor. The lower component of the prosthesis is carefully aligned for optimal weight-bearing and function.

In the afternoon, the patient is taken to the physiotherapy department where he stands and walks between parallel bars, bearing a weight of usually no more than 30 pounds on the prosthetic foot. This measurement is obtained by the patient standing on the scales. We limit weight-bearing to what the patient can tolerate and do not prolong it unduly.

Successive days

Decisions about each step of the procedure are made by the physician,

*The "Knit-Rite" stump sock is manufactured by the Knit-Rite Company, 1121 Grande Avenue, Kansas City.

**Orthoflex is a product of Johnson & Johnson Ltd., 2155 Pie IX Blvd., Montreal, Quebec.



Below knee stump, following myodesis, showing anterior skin flap.

prosthetist, and therapist.

Usually walking with progressive weight-bearing is carried out two to three times daily, and any necessary adjustments in alignment are made if necessary. The sutures are removed 12 to 14 days postoperatively, and a new Orthoflex cast is applied to remain on a further two weeks. Following removal of the second socket, it is usually possible for the patient to be fitted with a permanent prosthesis. A bivalved cast may be worn at night to prevent edema and continue total contact for a limited period of time after the prosthesis is fitted.

With the permanent limb and its activated knee joint, the patient needs a further period of practice training for one to two weeks. The myodesis with the functioning muscles in the stump makes this period of training considerably easier than in former types of amputation. The patient and his prosthesis are checked periodically by physician and prosthetist to make certain the the prosthesis fits well and is functional.

Patient histories

A 17-year-old male, victim of severe electrical burns, had a conventional below-knee amputation of the right leg. Eight weeks after surgery he was fitted with a temporary socket. With partial weight-bearing, his stump shrank enough in the next three weeks to allow fitting of a more permanent prosthesis. One year later, he was still having difficulty obtaining a proper fitting socket.

Eight months following injury, after attempts to save the left leg had been unsuccessful, a below-knee amputation with an immediate prosthesis was carried out. In 10 weeks, the patient was discharged, walking well on both prostheses, ready for employment. He reported that the prosthesis that was fitted immediately after surgery was much more satisfactory than the earlier one.

A 48-year-old male with extensive atherosclerotic peripheral vascular disease that had resulted in gangrene of both feet, required bilateral below-knee amputation; a prosthesis was applied immediately to each limb. The patient was discharged six weeks after surgery, walked very well with one cane, and was able to return to his former employment.

An 81-year-old male required below-knee amputation for diabetic gangrene resulting from arteriosclerotic obliterative disease of the left leg. On the first morning after the operation he stood at the bedside, "feathering weight" for four minutes. In the afternoon he stood with 30 pounds weight and walked 20 feet with a 3-point gait. Ten days postoperatively, he was able to tolerate 60 pounds weight and walk with crutches 50 feet. In 19 days he was walking 300 feet.

He was discharged 36 days postoperatively, able to carry on living alone. Because of his age and medical condition, it is quite possible that he would never have come to prosthetic fitting if there had been the usual delay of two to three months after a conventional amputation.

Summary

The contraindications of this procedure are few when proper facilities and experienced surgeons and prosthetists are available. Without a thoroughly trained team of physicians, prosthetists, surgeons, and nurses, the procedure is not successful. Early ambulation and weight-bearing are essential if the patient is to walk with relative ease and live independently.

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Medication errors can be prevented

Despite new methods of dispensing medications in hospitals, errors continue to occur. Inadequate education, poor communication, and disorganization all contribute to this problem.

Sharon Thomas, B.Sc.N.

New systems of dispensing medications in hospitals are continually being developed and tested. Yet drug errors still occur. One expert estimates that 99 percent of errors that occur are never reported, and that the nurse involved may not even realize that the wrong patient received the wrong drug at the wrong time.[1]

Mismanagement and disorganization

The problem lies in inadequate education, faulty communication among doctors, pharmacists, and nurses, and just plain mismanagement and disorganization in the hospital.

Too often, the nurse does not keep up-to-date with the new drugs that are ordered for her patient; unaware of the correct dosage, use of the drug, and contraindications, she may fail to recognize signs of overdosage or side effects. The physician, too, is frequently at fault: his writing may be illegible; he may order medications verbally, instead of taking the time to write the order on the patient's chart.

In a study conducted in the United States, the researchers reported two main causes of drug errors: mismeasurement or miscalculation of the dosage of the drug by the nurse (31 percent), and selection and administration of the wrong drug (18 percent). The third most common cause of error (15 percent) was confusion about standing orders and when a certain drug was to be discontinued. This confusion was thought to be the result of doctors' unwillingness to abide strictly by the rules. This research team estimated that an error of some kind was made in 15 percent of all drugs administered.[2]

To reduce errors

How can a nurse prevent drug errors? First, she can suggest to the nurse representative on her hospital's drug committee ways to improve or alter the drug dispensing system. Second, she must make certain that she understands the uses, dosage, and effects of the drugs she administers. Third, she must take particular care to select the correct drug and measure it accurately. She should double check the drug and dosage before and after preparation.

The conscientious nurse may be frustrated by incomplete or out-of-date reference materials, or by an overcrowded, noisy medicine room located in a busy area. Obviously, she must press for change. In the meantime she should compensate by increasing her efforts to concentrate, or suggest that the number of nurses preparing and giving medications at the same time be decreased.

Technical details of preparation are also important. These include: thorough dissolving of tablets before withdrawing the solution into the syringe; complete withdrawal of all the solution in single-dose vials; and the labeling of mixed solutions with strength and date.

The correct patient

To eliminate possible errors, the nurse must know her patient and understand his illness. She must compare the medicine ticket with the identification band on the patient's wrist, as well as with the name on the patient's door or bed. Many nurses feel rather silly when they check a patient's wristband, particularly if the patient has been on the ward for some time. Even so, this final check must be made, because medications frequently are administered to the wrong patient – even though the staff *know* the patients.

Besides checking to make sure that the correct drug is given to the correct patient, the nurse must observe her patient for any untoward condition that might make her administration of the drug dangerous. For example, she should check the patient's pulse rate before giving digitalis, and question the frequent administration of a tranquilizer to a patient who appears extremely drowsy.

Most medications should not be left at the patient's bedside. The nurse is responsible for making sure that the patient takes his prescribed medication. This is not merely a moral responsibility; the hospital and its employees are *legally* responsible for the complications that could result from a patient not receiving medication or from a patient who accumulates a number of pills and takes them all at one time.

Mrs. Thomas, a graduate of the Calgary General Hospital and Queen's University, now lives in London, Ontario.

High rate of error

None of these suggestions is new; every nurse has been taught these precautions plus many more. Why, then, the high rate of error?

The U.S. study mentioned previously came to three conclusions on why drug errors continue to be made: [3]

1. The modern hospital has not kept pace with the rapidly increasing demands of modern drug therapy.
2. There appears to be a serious lag in the effective and accurate distribution of drugs within the hospital.
3. Many errors seem to suggest faulty training in nursing schools in matters of drug preparation and/or lack of emphasis on the importance of performing these tasks accurately; others suggest a lack of proper equipment and facilities; most suggest need for greater systemization and controls.

The third conclusion is of most interest to nurses, mainly because it is within their sphere of influence.

Summary

Too often, the administration of medications becomes merely a routine. Also, in situations where doctor-nurse communication is minimal, the nurse is unaware of the doctor's specific goals for a patient, and therefore does not understand why a certain medication is ordered. In too many hospitals, questions about drugs and their dosage are not encouraged. The result is illustrated by this story, which appeared in *Medical Economics:*

The operation was being performed with spinal anesthesia. The surgeon, noting that the patient was getting restive, decided a sedative was indicated. So he said to the circulating nurse, a student on her first O.R. tour: "Give 15 milligrams of morphine to the anesthetist, please." The young nurse eagerly loaded the hypodermic, took it over to the preoccupied anesthetist, and gave it to him – in the upper arm. Soon the man became euphoric and had to be replaced. By then, the nurse already had been. [4]

Unfortunately, most drug errors are not brought to our attention in such and amusing fashion.

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□



To eliminate possible error, the nurse compares the medicine ticket with the name band on the patient's wrist.

The nurse makes certain that she understands the use, dosage, and effects of the drugs she administers.



research abstracts

Bailey, A. Joyce. *Relationships between attitudes to nursing, job satisfaction and professional organization membership.* Cleveland, Ohio, 1968. Thesis (M.Sc.N.) Western Reserve.

This study was done to determine nurses' attitudes to their profession, image of nursing, and level of job satisfaction, and to determine the relationship of these variables to professional organization membership. The stimulus for this study emanated from the continuing decline in numbers of nurses who were members of their professional organization in Ontario (Registered Nurses' Association of Ontario) and the lack of compulsory membership for nurses in that province. Conflicting opinions regarding the desirable pattern for education of nurses in Ontario was also a stimulus.

It was thought that a complex variable – general positive attitude to nursing – existed and was composed, in part, of attitude to the profession, image of nursing, job satisfaction, and membership in the professional organization. Hypotheses were formulated that predicted positive relationships among the aforementioned variables.

The method used was that of mailed questionnaires to registered nurses em ployed full-time in the province of Ontario. A total of 361 questionnaires were mailed; 151 returns were usable. Relationships among variables were explored and member and nonmember subgroups were compared with .01 selected as the level for significance.

A general positive attitude to nursing was not demonstrated. The hypotheses formulated about relationships among the attitudes, satisfaction, and organization membership variables were not accepted No differences were found between members and nonmembers on the major variables. The groups also did not differ with respect to age, marital status, residence, nursing education (basic and post-basic), or place of employment variables.

Differences between members and non-members were found to exist regarding present enrollment in educational courses and mean salary obtained. The groups also differed in distribution by level of positions held when positions were dichotemized at the head nurse level.

Differences between members and non-members were found as to whether membership in the RNAO was required or not by employers. No relationship was demonstrated between salary levels and employer expectations of membership.

Membership does not appear to represent more professional commitment or job satisfaction. Whether a nurse is a member or not, she tends to hold much the same view of nursing and derive much the same satisfactions from it. Lack of demonstrable differences between member and nonmember subgroups should stimulate a change of thinking by professional organizations with regard to recruitment of members.

Currently, membership may represent primarily attitudes and expectations of employers and employing agencies. Unless there is a change in the future, the professional association may function solely for the economic security of nurses.

Purushotham Devamma. *The relationship between continuity of nurse-patient assignment and the patient's knowledge of self-care.* Montreal, 1968. Thesis. (M.Sc.N.(A)). McGill.

This research study examined the relationship between continuity of nurse-patient assignment and the patient's knowledge of self-care. The study, exploratory in nature, was carried out in three general teaching hospitals. Thirty patients with colostomy were selected for the purpose of the study. A special instrument was devised, based on a set of criteria for optimum colostomy care, to measure the patient's knowledge of self-care. The number of nurses who cared for each patient over a 15-day period was determined from the unit nursing assignment sheets.

The data were analyzed using Spearman's coefficient of rank correlation and analysis of variance.

A significant association between continuity of nurse-patient assignment and the patient's knowledge of self-care was found, r(rho) = .744.

The findings support the hypothesis.

Shantz, Shirley Jean. *A study to determine who, in the opinion of nurses and physicians, should be responsible for teaching the hospitalized patient.* Seattle, Wash., 1968. Thesis (M.N.) Washington.

Studies have shown that while many patients desire health information, and its provision may positively influence their response to therapy, nurses and physicians show little agreement in their definition of their teaching role.

The purpose of this study was to compare the responses of a group of nurses and physicians who work together in a Canadian active treatment hospital to a questionnaire that asked them to select who they felt should be responsible for teaching in 20 hypothetical situations. The options allowed the respondent to indicate that he felt the responsibility should belong to the physician, the nurse, or be shared by both.

The 102 nurses chose the "nurse's responsibility" option most frequently, and the 64 physicians selected the "shared responsibility" option most often. A significant difference in these responses was found when they were submitted to the chi-square test. Neither the nurse's position, the physician's specialization in practice, nor the individual's affiliation with a particular nursing unit were found to have significantly influenced the responses.

The majority of the respondents varied their responses, indicating that each situation must be assessed individually, but consistently selected a more independent teaching role for the nurse in situations where the patient or his family needed to learn specific skills, than when understanding of the illness or therapy was required.

Williams, Marguerite C. *A comparison of the perceptions of public health nurses and their alcoholic patients regarding the priority ranking of nursing needs.* Boston, 1968. Thesis (M.Sc.N.) Boston University.

The plan authorized by the Ontario government to combat alcoholism called for greatly expanded education of members of the health professions to increase their skill in helping alcoholics. In an effort to contribute to the improvement of a developmental factor of the nursing care plan, this study was undertaken by mail to determine how the perceptions of public health nurses vary with the perceptions of their patients dependent on alcohol with respect to the priority rating of nursing needs. The sample consisted of five public health staff nurses employed in two public health departments and

their five patients who were dependent on alcohol.

From statements submitted by a group of alcoholic patients and a group of public health nurses, 14 nursing needs were identified Based on these needs, 14 statements were developed and printed on individual cards. Each patient, provided with one set of 14 cards, was asked to place them in rank order according to the relative importance of the statements for him. Two sets of cards were provided for each nurse participant; the nurse was asked to place the cards in rank order twice: as she believed her patient would rank them and as she perceived their therapeutic importance for him.

Data analysis revealed no statistical correlation between individual patient rankings and corresponding nurse opinions of patient preferences or nurse perceptions of the therapeutic importance of the statements. Two nurse responses, however, showed statistical correlation between the nurse's own two rankings. Such correlation could indicate the possibility that the nurse's opinion of her patient's perceptions was a projection of her own beliefs about his therapeutic needs.

The findings and conclusions of this study led to the recommendation that further study be undertaken to refine the tool in an effort to gain more valid comparisons of patient-nurse perceptions of nursing needs.

Richard, Sister Huberte. *A study of the attitudes of nurse faculty members in a selected Canadian province in relation to their educational functions.* Washington, D.C., 1963. Thesis (M.S.) The Catholic U. of America.

The purpose of this study was to identify the attitudes of nurse faculty members in a selected Canadian province in relation to three educational functions, namely: teaching, curriculum development, and research related to the educational program Thirty-six full-time nurse faculty members from 10 schools of nursing in a selected Canadian province constituted the sample for this study.

The descriptive survey method was used. The instrument designed for the collection of the data was an attitude inventory constructed after the Likert technique for the construction of attitude scales. This was coupled with general information relating to the length of time participants spent in teaching positions. The 103 statements on the attitude inventory were classified under 3 categories – social environment, personal dimension, and role dimension – in relation to the 3 educational functions.

Before sending the inventory to the selected schools, it was submitted to a trial study after which the responses were scored and a critical evaluation for reliability was done by using the split-half method; the reliability of the tool was found to be .72 for the half; when correlated for the whole inventory, it was .84. The criterion of internal consistency was applied to determine the discriminative powers of the statements by using the upper and lower four participants; the results showed that some statements did not discriminate. After revision, the inventory consisted of 97 statements.

An attitude rating scale was constructed on which the attitudes of participants and of faculty from the schools could be located on the attitude continuum – highly favorable, favorable, less favorable, unfavorable, and highly unfavorable.

The analysis of the data obtained from the inventory revealed that the majority of the participants considered individually had a highly favorable attitude toward social environment relative to teaching, a favorable attitude toward social environment relative to curriculum, and a less favorable attitude toward social environment relative to research. The majority of participants had a favorable attitude toward personal dimension and role dimension relative to teaching, curriculum, and research.

Faculty from the majority of the schools had a favorable attitude toward teaching, curriculum, and research as indicated by the total score. Faculty from the majority of schools had a favorable attitude toward social environment, personal dimension, and role dimension relative to teaching, curriculum and research as indicated by the sub-scores. The number of schools with highly favorable attitude toward social environment, personal dimension, and role dimension relative to teaching were four, two, and five respectively. No highly favorable attitudes toward research were shown by faculty from any schools. Faculty from one school had a highly favorable attitude toward social environment relative to curriculum

The coefficient of rank correlation showed no significant relationship at the 5 percent level between the attitudes of faculty members and their experience in the present teaching position.

The writer is aware that numerous factors could influence the attitudes of individuals. In this study, however, only one variable, the length of time participants spent in teaching and in present teaching position, was considered. The number of statements for each category and for each function varied greatly. This variation might have had an influence on the findings of the study. The negative statements in the inventory seemed to have been interpreted with difficulty by some of the participants. The size of the sample would not permit generalization from the findings outside the province selected for the study.

Administrative tasks, such as budget and annual report preparation, may be perceived as prestige functions by many directors of nursing, whereas the acquiring of equipment for a patient unit may be seen as a low prestige job. In university-centered hospitals it may be expected that there is more stratification in the nursing service hierarchy than in the community hospital. This is due to associate and assistant directors of nursing. This stratification may prevent the nursing supervisor from sharing in budget and annual report preparation.

McEwan, Elaine A. *Women's feelings about the figure change in pregnancy.* New Haven, Conn., 1968. Thesis (M.Sc.N.) Yale U.

The purpose of this study was to discern what feelings women had about figure changes in pregnancy, to see if those feelings were a problem to her and, further, to see what factors might be related to those feelings.

There were 40 married women in the sample, 20 clinic patients, and 20 private patients. The sample was distributed over 4 gestational periods: early (18-24 weeks); middle (28-32 weeks); late (38-40 weeks); and within 48 hours postpartum Data were collected by the use of an interview and measurement scales. The responses obtained from the interview concerning the figure change in pregnancy were rated and, as a result, each woman was placed along a 5-point continuum from dissatisfied to satisfied. Four women were rated as dissatisfied, 17 as somewhat dissatisfied, 10 as neutral, 9 as somewhat satisfied, and none as satisfied. The expression of neutral feelings was greatest at 18-24 weeks and, as the gestation progressed, expressed feelings of dissatisfaction increased

Feelings of dissatisfaction seemed to be related to such factors as lower social class, youth, negative feelings about menstruation, and a less than normal weight gain. Feelings of satisfaction seemed to be related to age (30-39), planned pregnancy, higher social class, and positive feelings toward menstruation.

The measurement scales were useful as research tools but, in practice, one or two of the questions from the interview that were very discerning should be sufficient to give the nurse cues as to whether a mother has dissatisfied, neutral, or satisfied feelings about the way she looks. The amount and kind of support each woman received from her husband appeared to influence the way she viewed herself.

The results of this study seem to indicate that body image during pregnancy may be a problem area, and that mothers need moral support so they do not feel unattractive during pregnancy. □

books

Behavioral Science, Social Practice, and the Nursing Profession by Powhatan J. Wooldridge, James K. Skipper Jr. and Robert C. Leonard. 108 pages. Cleveland, Ohio, The Press Of Case Western Reserve University, 1968. Canadian agent: Burns & MacEachern Ltd., Don Mills, Ont.

Reviewed by Anna Gupta, Associate Professor, School of Nursing, University of Windsor, Windsor, Ont.

To many professional nurses, this book would be an eye-opener to the facts about the present status of nursing theories, nursing guidelines, and nursing practices.

The book raises the fundamental issue of the responsibilities of the nursing profession in developing guidelines and theories in the areas of its "independent" functions. The authors attempt to differentiate nursing duties carried out under medical guidelines to meet the biophysical needs of the patient from independent nursing duties that meet the situationally-derived needs or the psycho-social aspects of patient care. They point out that nurses are solely responsible for meeting such situationally-derived needs of the patient, independent of the physician or his guidelines.

The authors define the role and unique functions of nurses as those of social practitioners.

The book's essential purpose is to show the way in which the "accumulated theoretical and methodological knowledge of the behavioral sciences can be used to improve the effectiveness of nursing." However, the authors caution against blindly applying principles of social sciences, and stress the need for experimental nursing research to be conducted in actual nursing practice so that the principles of social interaction and human behavior that will be useful in formulating theories of nursing practice can be identified. The authors say that such research will also help to test general proposals about human behavior and, quite possibly, new theories in sociology and psychology will be developed from studying nurse-patient interaction.

Though the book seems brief and of a simple format, the thoughts expressed therein are rather complex and of grave importance to the nursing profession. One needs to read the book two or three times to appreciate its purpose and the approach of the writers, and to realize the challenges of the issues revealed.

Problems in Child Behavior and Development by Milton J.E. Senn, M.D., and Albert J. Solnit, M.D. 268 pages. Toronto, Macmillan Co. of Canada, 1968.

Reviewed by Jean Jenny, Inservice Education Director, Riverside Hospital of Ottawa, Ottawa, Canada.

Many changes have taken place in pediatric practice during the past few decades. A favorable shift downward in the frequency of childhood disease has not been paralleled by a decrease in the number of people emotionally disturbed to a degree where they need professional help. This text was written to assist the general practitioner and pediatrician to update their present practice by presenting to them the newest methods of approaching the problems in child and family behavior. The initial education of medical and nursing staff is often inadequate in the fields of general psychology and emotional disturbances, and this book will be of distinct value to anyone engaged in pediatric health care and family counseling.

The authors describe the philosophy and methods used at the Yale Child Study Centre in dealing with parents and children in distress. The newest concepts in child development, psychiatry, and psychoanalysis are presented. The selection of theoretical and clinical concepts is eclectic, including the most popular theories of Freud, Piaget, and Erickson. The book characterizes the developmental phases as they appear chronologically and as they evolve qualitatively in the growing child. The dominant characteristics portraying each stage, with their accompanying affective and cognitive features, are discussed and the behavioral aspects of the child's development are viewed longitudinally.

The breadth of the book encompasses pregnancy, the newborn, premature, and young infant, the toddler, the school age and preadolescent youngster, and the young adolescent. Pediatric evaluation and therapeutic management are discussed in depth and a large chapter on special problems includes various psychiatric disorders, rape, suicide, adoption, fatal illness, and preparation for hospitalization. The depth of the material makes it of worth to a professional person and it would contribute greatly to the nurse's postbasic clinical knowledge. There is an excellent index at the back but no bibliographic references are included. The authors' style is crisp and authoritative and the book, as a whole, is eminently readable.

The philosophy of the text stresses that psychologic pediatrics encompasses comprehensive medical care of the child in the context of his family and community, and underlines the need for embracing the whole person and the whole family. The sick child, rather than the disease itself, occupies the authors' attention. I would recommend this volume for all pediatric nursing libraries.

A striking feature of this text is the grouping together of seemingly different conditions that are basically the same from the surgeon's point of view. For example, one chapter entitled "obstruction" lists obstructing agents and conditions in which the free flow of fluids and impulses is hampered, thus requiring surgical intervention. Cardiac arrest and respiratory failure are presented in a clear and concise manner in this chapter.

The chapter on iatrogenic conditions is recommended reading to nurses who play an important role in prevention of disease and the safety of the patient. The authors outline a variety of disorders, most of which can be prevented by the vigilant and skillful nurse. Although not mentioned in this book, there are serious legal problems involved in iatrogenesis of which the nurse should be constantly aware.

This text would be a valuable, up-to-date, quick reference in the ward library of both an adult and children's ward. As it presupposes basic preparation in surgical nursing, it would be of most value to the senior student and graduate nurse.

The Knife Is Not Enough by Henry H Kesler. 295 pages. New York, W.W Norton & Co. Inc., 1968. Canadian agent: George J. MacLeod Limited Toronto.

Reviewed by Valda Lawford, Information Service Officer, Manpower Utilization Branch, Dept. of Manpower & Immigration, Ottawa, Canada.

The title of this book conveys the philosophy that has guided the author through a medical career in which the emphasis has been not so much on the excellence of his technique as an orthopedic surgeon but on his dedication to the principles of rehabilitation. He con-

tinues to demonstrate his belief that it is not enough for the surgeon or physician to provide optimum medical or surgical care: that his work is not done until he sees that his patient has received all the other services – physical and occupational therapy, prosthetic devices, vocational counseling, training and placement – that will enable him to resume his former place in society or assume a new role that is productive and satisfying.

The author emphasizes this belief through his distress when, as a naval surgeon, he had to perform many amputations without the opportunity of seeing that his patients got satisfactory follow-up services. His reassignment to the Naval Hospital at Mare Island was a relief to him for he was able to develop a rehabilitation program for his amputee patients.

As Dr. Kessler recounts his experiences with the Workmen's Compensation Program, The New Jersey Rehabilitation Commission, and later at the Kessler Rehabilitation Center, the reader sees some of the problems of ignorance, misconception, prejudice, and public apathy that have to be overcome in developing a rehabilitation program in any community.

Dr. Kessler has traveled widely and a large part of his book concerns his experiences on the international scene. In early years, he sought out leaders in surgery and prostheses, always on the alert for new techniques and advances that would help his own patients. From 1950 on he acted as a United Nations expert on rehabilitation to help countries establish or develop their rehabilitation programs. As a representative of the International Society for Rehabilitation of the Disabled, he visited many countries, promoting the value of rehabilitation and helping many handicapped individuals.

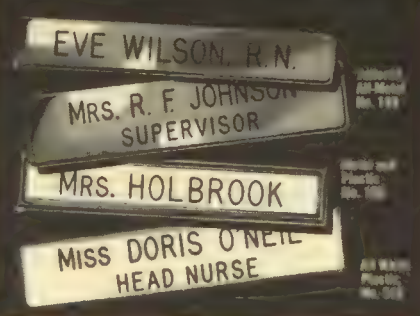
The reader, through Dr. Kessler's experiences and travels, will meet many world leaders in the field of rehabilitation. He will also get glimpses of the effects of war and the struggles of countries to care for their handicapped citizens at the same time that they are faced with other problems of reconstruction.

The book is enlivened with personal experiences, character sketches, and anecdotes that make for interesting and entertaining reading.

Principles and Methods of Sterilization in Health Sciences, 2nd ed., by John J. Perkins. 560 pages. Springfield, Illinois, Charles C. Thomas, 1968. Canadian agent: Ryerson Press, Toronto. *Reviewed by Frances Howard, Consultant, Nursing Service, Canadian Nurses' Association, Ottawa.*

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past 10 years but a brief and explosive interlude in the history of health sciences. Personnel, charged with the preparation and sterilization of medical supplies, will welcome, therefore, the second edition of *Principles and Methods of Sterilization in Health Sciences.*

Whether the student or practitioner requires theoretical background on the nature of life and death of micro-organisms or practical information on the techniques and modes of sterilization, the text provides an adequate reference on the most recent developments in these fields. Its value as a reference book is enhanced by the inclusion of numerous illustrations. For those who wish to pursue the subject further, the author has appended extensive bibliographic references to most chapters.

The text is written for use in hospitals, clinics, laboratories, allied institutions, and services. Personnel in hospitals will find additional help from the chapter on the organization and function of the central service department.

Basic Psychiatry by Myre Sim and E.B. Gordon. 262 pages. London, E. & S. Livingstone Ltd., 1968. Canadian agent: Macmillan Company of Canada, Toronto.
Reviewed by Karen V. Walker, Assistant Director of Nursing Education, Clarke Institute of Psychiatry, Toronto.

This small, easy-to-handle book consists of short summaries of definitions, etiology, theories, and therapies, covering a great breadth. Some of the sections are: psychology, psychopathology, psychopharmacology, genetics, specific disorders, social psychiatry, child psychiatry, physical treatments, and legal aspects.

As a nurse educator, I do not hesitate to recommend it as a reference book for beginning student nurses. It gives them a summary of the field of psychiatry, from which further depth study may be pursued. It presents information in a factual, unbiased and concise manner, which is commendable in such an abstract field.

This book would also be of use to graduate nurses beginning work in a psychiatric setting. If it were available on the wards, these nurses could quickly obtain basic information that would assist them in understanding the patients and the communication of other disciplines.

This book could also serve a useful purpose in the general hospital setting. Nursing is growing in its ability to view the total person, rather than separate aspects. If this book were available to nurses in obstetric, pediatric, I.C.U. and medical-surgical settings, it could serve as a quick reference in any area in which psychiatry has contributed to the understanding of the total person.

In summary, this book offers all the health professions a reference work on basic psychiatry. It provides breadth but not depth, and is a useful aid for this purpose.

Chemistry: Inorganic, Organic and Biological by Philip S. Chen. 263 pages. New York, Barnes & Noble, Inc., 1968.
Reviewed by Shirley W. Stephens, Instructor, Nursing Program, British Columbia Institute of Technology, Burnaby, B.C.

Prepared for the "College Outline Series" published by this company, this book is intended to be a study guide for students taking a course including three broad areas of chemistry – inorganic, organic, and biological. It would also be of value to graduate nurses for reviewing basic chemistry material and to members of the paramedical professions for reference.

In each chapter the author presents a comprehensive summary of the topic discussed. The beginning chapters review basic concepts including radioactivity, radioisotopes, electrolytes, and ionization. In the chapters on organic chemistry, the author discusses the chemical nature of carbohydrates, lipids, and proteins, and includes numerous tables classifying commonly used compounds – with many applications to medicine. The remaining chapters summarize the metabolism of the nutrients and the chemistry of blood, urine, vitamins, and hormones. However, there is insufficient material included on body fluids, electrolytes, and acid-base balance to be of optimum use for nurses.

In addition, there is a reference table keyed to standard textbooks, a detailed glossary, and a self-test for review purposes.

This book would be a valuable reference source for students and graduates of health professions.

Health Visiting Practice by Mary Saunders. 112 pages. Toronto, Pergamon Press, 1968.
Reviewed by Ruth E. Aiken, Director of Nursing, Department of Public Health. Borough of York, Weston, Ont.

This book was written for the practicing health visitor and in particular for mature women who are beginning field work. The author has found that the mature nurse entering the health visiting field has need of practical detail to give her confidence.

The book begins with an outline of the organizational structure of public health services in Britain. The author admits that one of the difficulties in writing about health visiting is the variation in patterns of organization. Therefore she has tried to choose a "happy medium" in describing the lines of authority and responsibility.

The book describes an interesting concept of health visiting, which is still largely in the pilot stage in Canada. The health visitor works attached to or in liaison with the general practitioner, either in a single or a group practice. An absorbing chapter is devoted to methods of developing this service.

Two chapters are devoted to methods of writing reports and keeping records. These chapters are detailed, elementary, and the methods are useful parochially.

The chapters dealing with infant and child care, the school health service, and the after-care of patients discharged from hospital, offer useful advice to the beginning health visitor about planning her work and setting priorities. Some routine procedures are described in detail.

A perceptive discussion about geriatric work and related welfare services that concern the health visitor hints at the frustration frequently felt by the health visitor when she attempts to interest others in the care of the aged.

The author discusses briefly the health visitor's liaison with workers of other disciplines and outlines the legal framework on which child protection in Britain is based. She describes some of the differences in viewpoints of the social worker and the health visitor in dealing with situations involving child protection.

Since this book deals at length with material that most Canadian health agencies provide in their local or provincial procedure manuals, its use is limited except for purposes of comparison.

Psychiatry For Nurses, Social Workers And Occupational Therapists by C.P Seager. 231 pages. London, Willian Heinemann Medical Books, Ltd. 1968. Canadian agent: Burns & MacEachern Limited, Don Mills., Ont
Reviewed by James B. Birley, Psychiatric Nursing Instructor, The Saskatchewan Training School, Moose Jaw.

Dr. Seager has designed this book "to introduce the newcomer to psychiatry to those aspects of the subject which are more important in helping her to deal with the many problems that she is likely to meet in her work." He hopes that it will be of value "to the psychiatric nurse to the occupational therapist, the social worker and to all others who come into this field of medicine."

For three main reasons, Seager's book would be of questionable value to Canadian psychiatric personnel: 1. A large portion of his text is distinctly British Canadians might read, for interest only about the General Nursing Council, the

Mental Health Act of 1959, the British legal and administrative aspects of marriage, divorce, sterilization, and abortion, or of criminal responsibility or drug dependency. 2. Treatment and rehabilitation of the emotionally ill and the mentally retarded in Saskatchewan and in many other parts of Canada are a step or two ahead of that reported in Dr. Seager's book. 3. The author has condensed too many topics into one small book. In 225 pages he includes an introduction, a history of psychiatric nursing, and chapters devoted to human development, admission and examination of the patient, development of intelligence, the emotions, thinking, personality and its disorders, psychiatric treatment, legal and administrative aspects, psychiatric emergencies, and special psychiatric units.

The Treatment of Mental Disorders in the Community, edited by Gerald S. Daniel, and Hugh L. Freeman. 83 pages. London, Baillière, Tindall and Cassell, 1968. Canadian agent: Macmillan Co. of Canada, Toronto.
Reviewed by Lois Kirkland, Public Health Nurse, Ottawa, Canada.

This book contains papers presented at a symposium held at the Royal Society of Medicine, London, in November 1967. The purpose of the symposium was to present basic problems in providing community services in the treatment of mental disorders and to illustrate the successful developments of certain units in Great Britain.

The movement toward treatment of the mentally ill outside hospitals seems to be the common purpose of each writer. One writer discusses the integration of mental health services within the community; another indicates the value of day care units in relieving the general hospital psychiatric inpatient unit. The value of keeping elderly paranoid patients out of hospital is reported by a doctor who organized community services for aged persons. The use of drugs in keeping patients out of hospital is reviewed. One author outlines an organization of domiciliary psychiatric nursing care, which proves successful to the main purpose of the symposium. Another writer, who was a pioneer of industrial therapy, examines the value of essential ingredients for setting up a useful service. Finally, the principal medical officer, ministry of health, discusses in general terms methods of increasing the efficiency of mental health services.

The book indicates that community health care does not mean care and services "outside the hospital." The hospital must be considered an integral part of the community service – a part providing one aspect of health care. Comprehensiveness, coordination, and continuity with other services are shown as basic ingredients of community care. The writers' reports of their work demonstrate the use of these ingredients in providing community mental health care. It seems logical that these applications could well be ones to bring about changes in health care in general.

This book is a series of reports from men who have worked closely with units that provide progressive community service in the care of the mentally ill. As such, the book has little practical value for nurses, except perhaps for nursing administrators who are organizing special services of this nature. However, the contents broaden the reader's concepts and understanding of the trends in mental health care. Trends of this type could become established practice in total health care in the future.

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Surgical Principles by James Moroney and Francis E. Stock. 371 pages. Edinburgh and London, E. & S. Living-



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books

stone Ltd., 1968. Canadian agent: The Macmillan Company of Canada, Ltd., Toronto.
Reviewed by Helen T. Nightingale, Supervisor, Queen Elizabeth Hospital, Toronto.

The authors of this book are English surgeons who are addressing chiefly the student surgeon. On browsing quickly through the pages, one is impressed by the simplicity of presentation. That a picture is worth a thousand words is certainly evident in this profusely illustrated text. The photographs and color as well as black-and-white sketches facilitate easy, rapid reading.

Being a medical text, this book would be better reviewed by a surgeon. But being a colleague profession, nursing can be enhanced by a knowledge of the principles by which the surgeon is guided. This review in no way implies sophistication in the practice of surgery, but is concerned with the implications the text has for surgical nursing.

Just three pages long, Chapter 1 deals with the cell, its structure, and environment. The indication for surgery is succinctly stated at the end of this short chapter: "The need for surgery arises from changes whose ultimate impact is on the life of the cell which may be deformed, deprived or poisoned." The next chapter provides a wealth of material on congenital anomalies and includes abnormal development due to maternal problems, such as rubella and the use of thalidomide in early pregnancy. Up-to-the-minute information is presented in all chapters; the nurse who is familiar with this information could understand the patient better and work more effectively with the surgeon.

Human Sexual Behavior and Sex Education: Perspectives and Problems, 2nd ed., by Warren R. Johnson. 235 pages. Philadelphia, Lea & Febiger, 1968. Canadian Agent: Macmillan Company of Canada, Toronto.
Reviewed by Doris S. Thompson, formerly Nursing Instructor, The Children's Psychiatric Research Institute, London, Ont.

In an era preoccupied with sex, changing morals, and demands for sex education, it is rewarding to read a frank, realistic, but somewhat shocking book on human sexual behavior and sex education.

The subject material is presented in an organized and interesting manner. References at the end of each chapter support the material presented.

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University of Alberta Hospital, Edmonton, pp. 48, 49
Riverside Hospital, Ottawa, & Dept. Health & Welfare, p. 51

The author is concerned with helping people gain greater understanding of themselves and others through increased awareness of the dynamics of sex in modern life. With this understanding the educator may find directions that will lead humanity to relationships of meaning and fulfillment.

The book opens with a description of sex education, its nature, and the scope of the challenge. This first chapter outlines the problems of sex education and closes with a list of personal qualities the author believes teachers of sex education should possess; these include an under standing of one's own sexuality.

Sexual attitudes, morality, and laws are traced throughout history, and include old Testament Jewish patterns and the Puritan influence. The author describes the dilemma of rearing children in a sex-centered society, which is at the same time antisexual.

Misconceptions related to sexual behavior, such as masturbation resulting in insanity, impotent men being less masculine, and "frigidity" being evidence of low femininity, are presented. Recent studies are quoted to support the author's views.

A full chapter is devoted to sex and the law. The author points out the inconsistency of laws related to sexual behavior from state to state. He considers many laws to be outdated.

In an effort to develop a better understanding of human sexual behavior in a "natural state," the author includes studies on primitive societies and their sexual behavior. He also examines sexual behavior in modern societies.

Seven theories of sex education are outlined. The author does not outline a curriculum on sex education, but tries to develop in the reader a better understanding of human sexual behavior by discussing the biological-psychodevelopmental, historical-linguistic, legal, moral, and cultural aspects.

This book will help mothers understand their children, nurses understand their patients, teachers understand their students, and adults understand one another.

Inservice Education by Russell C. Swansburg. 339 pages. New York, G.P. Putnam's Sons, 1968. Canadian agent: Macmillan Company of Canada, Toronto.
Reviewed by Lynsia Hylton, Coordinator, Inservice Education Program, The Princess Margaret Hospital, Toronto.

This is the first book on programmed instruction for inservice education that I have seen. It presents the basic concepts of inservice education for directors and instructors of inservice education systems, as well as for supervisors, charge nurses, and team leaders in agency settings.

The author defines inservice education as education designed to retrain people to improve their performance and their communicative ability, and to introduce them to the never-ending continuum of education.

The book contains ideas about what inservice education is and who should receive it; why we need inservice education; how to get inservice education off the ground; what the program should be; and the responsibility people have for continuing their own education. The appendix includes ideas for inservice programs, an inservice quiz, and a bibliography.

Each chapter is broken into sections beginning with an overall view of the topic to be discussed, followed by a series of short questions and answers. Programmed instruction gives the learner incentive to proceed with the task, through the gratification received by turning to the next page for the results of his effort. In this respect, the book is not at all dull reading. The questions become progressively more complex. Real-life situations are introduced in the form of case studies and each chapter ends with a summary of concepts that should have been learned.

This book is written by a nurse in the United States Armed Forces. The USAF spends much more time and money than a general hospital on a person's health and self-development. The reader should bear this in mind when reading about some of the ideal conditions mentioned in the book.

This book will be useful to persons already employed as inservice educators, as it may be used to evaluate and help improve existing methods. It puts inservice education into a frame of reference incorporating orientation, skill training, on-the-job training, and continuing education. In this book, a wealth of information is provided for persons about to become inservice educators or about to assume any position of leadership in nursing.

Continuing Education in Action by Harold J. Alford for the W.K. Kellogg Foundation. 153 pages. New York, John Wiley & Sons Inc., 1968.
Reviewed by Derek Pestell, Associate Director of Nursing, The Princess Margaret Hospital, Toronto.

The subject of this book is organized in a logical manner, starting with an over-view of adult learning, and progressing through the conception, planning, and building of the Kellogg-aided centers.

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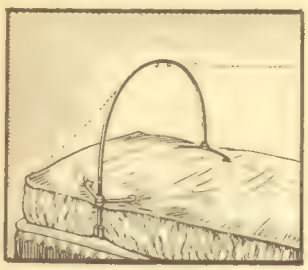
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these problems are described. This information would be valuable for anyone planning a building with both a resident and day-to-day populace.

One chapter illustrates the need for teamwork among a center's staff and members of the adjacent community, and the need for specialists in program coordination.

Emphasis is placed on the need for constant reevaluation of programs, in-service education, and research to find ways to improve existing programs. It is comforting to find that Dr. Alford and his peers at other Kellogg-aided centers are not without their problems in these areas.

An excellent chapter on the administrative aspects of an educational center such as this provides insight into the many problems that face such an institution.

The final chapter asks the question "Where do we go from here? " and herein lies the main purpose of Dr. Alford's book. The Kellogg Foundation has given financial aid to others to show what can and must be done in the field of continuing education; however, theirs is not a bottomless financial pit. Others must take up the challenge, if we are to be able to utilize man's ever-increasing mass of knowledge.

This is not a book to be read lightly or rapidly. The reader must ignore any initial response that all he is reading is a book publicizing the Kellogg Foundation.

Some of the points Dr. Alford makes are obvious – so obvious that many people forget them! I recommend this book to any educator or administrator who "knows where education is at." □

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Psychotropic drugs

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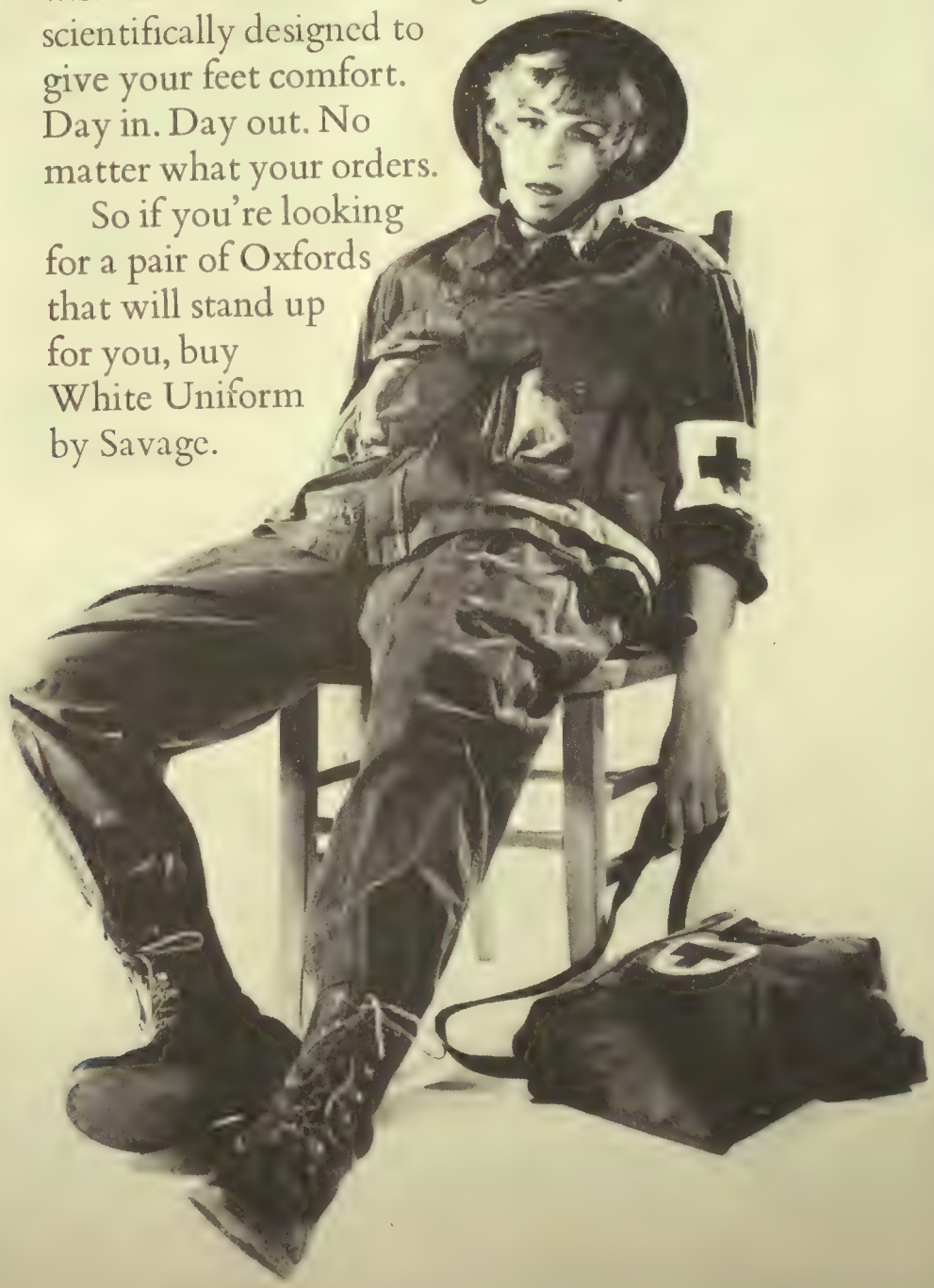
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A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 65, Number 6 **June 1969**

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letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Thought and action

I hope that all CNA members, both active and inactive, have read "Thought and Action" by Mr. E. Van Raalte (March 1969). He is to be congratulated on his report of the economics of the Canadian Nurses' Association.

At the same time, we cannot ignore the "News" section from which we can draw our own conclusions. Any provincial association that decides not to pay a CNA membership fee of $10 per member should realize the effect this decision will have on the national association.

The publication of French and English journals is commendable and should be continued, even though extra mailing charges strain the CNA budget. Also, we should acknowledge the fact that we cannot purchase very much today in quality and service for $10. We have to agree that since 1940 our association has gained in quality and stature as a result of better qualified personnel. In my opinion, there is greater strength in centralization than in decentralization.

If we have any pride in our profession, we owe it to our association to express our views on this issue.

It was my privilege to be elected as a representative of our district at the meeting of the Association of Nurses of the Province of Quebec last fall. I found it a most rewarding experience to see our provincial association in action, and to note the enthusiasm of the younger nurses present. – Gladys McDonald, Reg.N., Occupational Health Nurse, East Angus, Quebec.

The message so succinctly put forth by Mr. Van Raalte in the article "Thought and Action" (March 1969) explained the financial position of the Canadian Nurses' Association, but it would appear some basic facts are not spelled out and their absence is noticeable.

The breakdown of the $10.00 fee paid to CNA by each nurse who is a member of her provincial association incorporates the unknown cost of owning, operating and maintaining CNA House, total salaries paid, and travel expenses. Would it not be prudent for Mr. Van Raalte to reveal these possible large expenditures rather than apportion them to various areas? Perhaps knowing the hidden costs would take some of the wonderment away from "what happened to the $10.00 for CNA?

Advertising revenue from *The Canadian Nurse* would be interesting to know, coupled with the cost of producing the publication and its actual total mailing list.

It would appear from this article that CNA survival is based on members taking action. How can we realistically do so when so much is nebulous? – (Miss) Jacqueline P. Robarts, Reg.N., B.Sc.N., Principal, Osler School of Nursing, Weston, Ont.

The article "Thought and Action" by Ernest Van Raalte, and the February editorial reported that the CNA requires a fee increase.

Many nurses think it is most unfair that nurses who work on a casual basis or part-time pay the same registration fee as nurses who work full-time. The salary differences are too great to have registration fees the same for all. Perhaps registration fees should be in proportion to income.

If registration fees were in proportion to income, it would be necessary to have a separate licence fee. A nominal licence fee, such as Ontario has, seems fair and reasonable.

The Canadian Nurse is a wonderful journal and well worth the true costs to those who read it. Subscription to the journal could be voluntary. With the licence and journal subscription separate, registration fees in proportion to income would be feasible.

Perhaps the CNA's Ad Hoc Committee on Fee Structure would consider the above suggestions. – Beverley B. Barr, Winnipeg, Man.

Two-year vs. three-year programs

The undersigned members of the Committee on Research in Nursing of the Registered Nurses' Association of Ontario herewith register concern about the article "Two-Year Versus Three-Year Programs" by C.G. Costello and Sister T. Castonguay (February 1969).

This Committee believes: 1. that the theoretical rationale suggested by the authors' review of the literature is inadequate; 2. that the design of the study is not without serious methodological faults; for example, the assumed relationship between the educational objectives of the nursing programs and the student behaviors assessed in this study, and the inconsistency between the two outside raters and the implications drawn from their ratings; and 3. that the report of the study contains statements that give cause for serious concern; for example, this Committee questions the authors' interpretation of statistically non-significant differences between groups as "conclusive evidence" of the superiority of one group over another. Thus readers are misled into believing that the performance of the three-year students in this study was significantly better than that of the two-year students.

At a time when nursing is looking more and more to research for direction, it is imperative that it be reported accurately and meaningfully for members of the profession. Therefore, the Committee recommends that, prior to publication in the journal, research articles be reviewed by researchers who are competent to assess soundness of the design, implementation, and reporting of the research. It also recommends that *The Canadian Nurse* invite critiques of articles and research reports for publication, preferably in the same issue or closely following the initial publication of the article, study, or report. – Lucille C. Peszat, Secretary for Committee on Research in Nursing, RNAO; Margaret Allemang, Isabel Black, Margaret Cahoon, Rosemary Coombs, M. Josephine Flaherty, Amy Griffin, Lois Powell, Albert W. Wedgery.

Letters Welcome

Letters to the editor are welcome. Because of space limitation, writers are asked to restrict their letters to a maximum of 350 words.

Right no to strike

I am writing to express concern over the editorial (April 1969) that is so biased toward those nurse educators who chose to exercise their right to strike in Hamilton.

A good number of us, both in nursing service and education, have strong feelings about the use of the strike in our profession. Some of us are neither old nor particularly old-fashioned. Nor do we appreciate that the two teachers who exercised their right *not* to strike should be the brunt of derogatory comments in your editorial. We feel, in fact, that they should be entitled to an apology and a retraction of the term "turncoats."

The strong support of the strikers and of their view of the situation – and their view only – has been widely publicized by our national professional journal. We

(Continued on page 6

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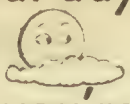
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letters

(Continued from page 4)

are particularly worried to find that the students, who remained quiet and non-committal, should be almost reprimanded for this in your editorial and encouraged, even incited, to support the striking teachers. The consequences of all of this are grave.

We want to express disapproval of the lack of fairness in the reporting and in the editorial of *The Canadian Nurse* on this issue. We also wish an apology to the two non-striking teachers (some of us even admire their courage and we know that not a few students do also). Next, we object to the encouragement of student involvement when the students had chosen, for their own reasons, *not* to support the strike.

Finally, we wish to express sadness and regret that a great lady and nursing leader, in the person of Miss Nightingale, should have been posthumously insulted by the use of the disrespectful nickname on the placard and the implication that she would have supported the strike action. It might do some persons considerable good to re-read their history of nursing and a biography of Miss Nightingale. Many of us feel she would have responded as a lady, an educator and a nurse practitioner whose primary concern would have been those in need of better nursing care, not her own remuneration.

We are not, in this letter, objecting to the strike action. We recognize the right of the strikers to act this way, if they wish. Whether we agree or approve is largely irrelevant. When those who disagree, however, for their own reasons are either not allowed to do so (and remain in good standing in our professional organization), and/or are ridiculed for their stand, it *is* our business. It has been erroneously assumed that all of us either are, or should be, in favor of the strike and of strike action for nurses.

We have been assured by several people that our views will be considered unimportant, non-representative, dangerously narrow, and out of date. Therefore, they will not be published. We feel that there are still honest attempts to air all sides of any situation in nursing in our professional journal. — Catherine Smith, Owen Sound, Ont.

Nursing assistant programs

It was very encouraging to read Dorothy Kergin's reasoned argument in favor of continuing nursing assistant programs (April 1969). I agree with Dr. Kergin that the CNA committee on nursing education policies, which include the gradual phasing out of all programs "that prepare practitioners, who, upon graduation, are not eligible for licensure as registered nurses," are not only "ill-conceived and poorly timed," but are out of touch with what is happening in the world around us.

Ten, or perhaps even five years ago, it might have been possible to move in the direction suggested by the committee on nursing education, i.e., to define only two nursing roles, differentiated by their basic educational preparation, but with both retaining eligibility for licensure as registered nurses. At that time the boundaries between the functions and the responsibilities of the diploma graduate nurse and the nursing assistant were less blurred, and their future roles appeared to be more easily differentiated.

What appears to have gone unrecognized has been the steady growth over the past decade in programs to prepare practical nurses for licensure. In British Columbia alone there are now over 3,500 practical nurses with current licensure; in the latest B.C. report on hospital statistics, it was noted that the non-professional nursing staff comprised over 43 percent of the total nurse force in hospitals. This group of nurse practitioners is most involved in direct patient care. It is interesting to speculate about which of the two nursing groups is actually having the greater impact on patients today.

It seems to me that to continue to deny the existence of this viable nursing force will only perpetuate a vacuous nursing predicament that has gone on too long. Undeniably, the nursing assistant is here to stay, and the time has come for us to accept this reality instead of looking to the past in an attempt to find the answers for the future. Dr. Kergin's prediction that unless we determine how best to utilize the nursing assistant, others will decide this for us, has already begun to come true. These decisions often have been made with only a polite acknowledgement of nursing's inherent right for self-determination.

I suggest that the nursing assistant programs should not only be continued but be strengthened. We know that graduates from these programs are continually being faced with responsibilities for which they have not been adequately prepared, and it is highly probable that in the future the demands upon their capabilities will increase. Attempts to impose unrealistic ceilings on practical nursing functions, or to consider shortening or eliminating these programs, can only be viewed as a defensive reaction against the inescapable changes occurring in the nursing and medical worlds.

If we are to grow as a profession, we must begin to assume a greater responsibility for the practice of nursing and its practitioners. We can do so by negotiating with the leaders of the non-professional nursing groups to find a mutual agreement on the best course for the future of

nursing. Together we should begin to explore our existing roles in the hope that through a joint reexamination of our similarities we can arrive at a clearer definition of our differences. We can only start to define these differences when we stop being rivals and stop worrying about our overlapping roles.

The practice of nursing will remain challenging only as long as nursing leaders constantly seek and promote new challenges, with each practioner being encouraged to develop to her fullest human potential. Nursing assistants have long proven their worth in providing patient care, and it is now the responsibility of professional nursing to give them the opportunity to make an even greater contribution.

I forsee the professional nursing role as primarily one of leadership and guidance, and of increased concern, not only for patient care, but for all those who are committed to patient care. To be effective leaders we must first put our own house in order. Only then can we know with reasonable clarity the full extent of nursing's contribution to the future health needs of our society. – Mrs. Carolee Bailey, R.N., Victoria, B.C.

Advances in nursing

The letter by M.H. Rajabally (March 1969) was rather galling, certainly to all degree nurses, and most probably to the majority of diploma nurses.

The query on the future trends of nursing reveals some lack of perceptiveness on the part of the writer. It is quite correct that a nurse at present cannot prescribe medication. Legally it is not tolerated. This in no way, however, implies that a nurse is incapable of minor diagnosis. Most practicing nurses, whether degree or diploma, have always diagnosed ills, then forwarded their opinion to the attending physicians who have usually corroborated their analysis and prescribed the remedies. The services of the physician, in many cases, could conceivably be performed by most highly qualified nurses. In 10 years perhaps hospital administrators will realize this fact.

"Nursing is becoming more and more theoretical because many nursing experts have left the hospital setting and disassociated themselves completely from patients." Nonsense!

Because nursing is becoming more theoretical, many educators have found it necessary to disassociate themselves from the patient. Advances in nursing, medicine, and administration techniques are constantly being made. Someone must accumulate and process this data for the benefit of students. The average professional nurse has not the time to handle the deluge of new knowledge. This is the forte of the educator; in most cases, but not always, this is a degree nurse who has been trained to acquire and process information as efficiently as possible.

Higher education is not intended to equip educators with manual dexterity, but to allow them to acquire knowledge, then forward this information to their students who, through practice, will acquire the dexterity to nurse patients adequately.

"I want – rather the patient wants – practice." How true! What nurse Rajabally fails to realize is that the ill person is the responsibility of the staff nurse, while the student is the responsibility of the educator-degree nurse. Both must acquire perfection in handling their respective patients. That the professional should adequately administer to the educator's patients or vice versa is simply not possible in this dynamic science.

Science has always been the mainstay of medicine and the applications today are subtle. Tomorrow's vistas appear fantastic – patient monitoring from a master situation, as in the space program, and diagnosis by computer. Today's student nurse is tomorrow's diploma (and I hope eventually degree) nurse. The patient, the doctor, and the profession will need her and her knowledge. I can only hope she obtains it through practice or education before it is needed. – Joan MacDonald, Instructor, Montreal. □



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news

CCHA Rejects CNA Bid For Representation

Ottawa. – For the eighth time in four years, the Canadian Nurses' Association's appeal for representation on the Canadian Council of Hospital Accreditation has been rejected. The executive director of CNA, Dr. Helen K. Mussallem, received this news in February from the Council, whose membership consists of the Canadian Hospital Association, the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, and l'Association des Médecins de Langue Française du Canada.

Since May 1965, the CNA has corresponded frequently with Dr. W.I. Taylor, executive director of the CCHA, expressing the association's deep concern about the lack of a representative from the organized nursing profession.

In July 1968, the Council again deferred CNA's request for representation until CCHA had received the report of its special structure study. This study, published by CCHA in December 1968 as the *Report of Research Project No. 1,* recommended that:

- Fifteen seats be provided on the board of the Council and that two of these be given to CNA.
- The executive office include three full time surveyors (one physician, one administrator, and one registered nurse.)
- Future surveys be conducted by a team.

To date, the *Report's* recommendations have been ignored.

The need to evaluate the quality of nursing in hospitals has been a matter of concern to CNA for a number of years. Several provincial nurses' associations have also expressed concern that not enough attention has been given to the evaluation of nursing care when hospitals are being assessed for accreditation. Representation on the CCHA would be one way for the CNA to meet this need.

In an interview with *The Canadian Nurse,* Frances Howard, CNA consultant in nursing services, suggested several reasons why the CCHA has not made the changes recommended in the *Report.* "The CCHA is a 'closed shop,' " she said, "and if nursing is represented on the Council, other hospital departments might also ask to be represented. CCHA believes that if the quality of medical care is good, patient care will be good," she continued. Miss Howard said that CNA should continue to press for membership on the CCHA; she believes that in the meantime there should be nurse representation on the standards committee and nurse participation on the survey team. She suggested, in addition, that the nurse surveyors be selected from a roster of nurses prepared by the CNA.

Margaret McLean, consultant in hospital nursing, Department of National Health and Welfare, and chairman, CNA committee on nursing service, told *The Canadian Nurse* that she supports CNA's bid for representation on the CCHA. "The CNA is committed by its objects to improve the quality of nursing services in Canada," Miss McLean said. "Many projects have been undertaken in carrying out this responsibility.

"The request for the CNA to be consulted when criteria for the assessment of hospital nursing service is being developed or revised in the accreditation program, and the request for a seat on the Council are two avenues through which the association would hope to maintain standards and improve the quality of hospital nursing service," Miss McLean said. "Since the majority of registered nurses are employed in hospitals," she continued, "participation in the development of criteria for evaluation of hospital nursing services and representation on the Council could be expected to forward the objectives of the CNA."

At the board of directors' meeting in February 1969, CNA suggested that the provincial nurses' associations send letters to their provincial hospital associations and the Canadian Hospital Association to interpret the merit of CNA's representation on CCHA. "Of all the professional services in the hospital, nursing is the only one that is continuous," Dr. Mussallem reminded the board members.

Whoo-Fur Pinned Down At Last



Sister Mary Felicitas, president of the Canadian Nurses' Association, pins Whoo-fur – the furry mascot of the ICN Congress – on lapel of Laura W. Barr, executive director of the Registered Nurses' Association of Ontario. Miss Barr is on the ICN Professional Services Committee.

ICN Receives $8,000 From AARN

Edmonton, Alta. – The Alberta Association of Registered Nurses has made a gift of $8,000 to the 14th Quadrennial Congress of the International Council of Nurses, to be held June 22-28 in Montreal. Seven thousand dollars are to assist CNA with the expenses of the Congress (reported in May 1969) and an additional $1,000 to purchase tickets to "Man and His World" for international guests who are not residents of North America.

Library Display At ICN Congress

Ottawa. — All available library references and other library tools for nursing will be displayed at the 14th Quadrennial Congress of the International Council of Nurses in Montreal June 22-28.

Virginia Henderson, author of *ICN Basic Principles of Nursing Care* and co-author of *Principles and Practice of Nursing,* is responsible for the exhibit and will be at the booth to answer questions. Miss Henderson will take part in a panel discussion on libraries in schools of nursing on June 24.

Team Nursing Workshops Held in Alberta

Ottawa. — Frances Howard, consultant in nursing service at the Canadian Nurses' Association, conducted workshops in Alberta in April. In Edmonton, more than 100 attended the workshop held April 8 and 9 in the auditorium of the school of nursing residence, Royal Alexandra Hospital. Over 75 were present in Calgary April 10 and 11 at the University of Calgary. The workshop was a "problem-solving" clinic on team nursing.

A group discussion was held by those nurses who had practiced team nursing, followed by a lecture on the philosophy and development of team nursing. A second group discussion centered on how to improve the team nursing already in practice related to the three basic aspects of team nursing: 1. the conference; 2. assignment of patients; and 3. the nursing care plan.

The final session included the role of inservice education in the implementation of team nursing, and the preparation of personnel for team nursing.

CCUSN Atlantic Region Assesses Need for Master's Program

Fredericton, N.B. — Challenges, curriculum, faculty selection, and the mechanics of setting up a master's program in nursing were topics presented by Dr. Shirley R. Good, consultant in higher education, Canadian Nurses' Association, at the Canadian Conference of University Schools of Nursing, Atlantic Region, meeting held April 21-22 in Fredericton.

"Since there are no specific Canadian guidelines for graduate education, we will have to continue to use USA material and modify it to meet our needs," Dr. Good told nurses from Newfoundland, Nova Scotia, and New Brunswick. Baccalaureate programs should be general in content with no major offerings in either basic or postbasic curricula," she said. Master's programs that are superficial or a makeup for weak or questionable baccalaureate programs, she explained, can only end in disaster at the first hurdle — rejection by the committee of graduate faculties.

Dr. Good stressed that preparation for both the nurse educator and the clinical specialist should include nursing content, functional preparation, and research in each year of the master's program. She pointed out that the teacher needs the ability to impart knowledge accurately and imaginatively, and the clinical specialist needs abilities in teaching and "human organization." The level of knowledge (cognitive), skills, and attitudes (affective) to be attained as the educational outcome of the program must be determined, she said.

"Faculty selection is extremely important," Dr. Good continued. "The criteria for faculty include preparation to a level one degree higher than the students; scholarship and creative ability; an excellent teacher; professional experience for which she is sought for consultation; and demonstrated ability in research."

Dr. Good cautioned directors to have a heterogenous faculty, make provision for present faculty to become more productive, and recognize that the initiation of a master's program will not alleviate faculty shortage. Dr. Good believes that the faculty should develop the educational program in cooperation with other university departments that will contribute

(Continued on page 12

Meet The ICN Staff


Quinn


Duvillard


Shout


Pickard


Thompson


Seivwright


Tardivelle


Redman

Eight staff members of the International Council of Nurses, Geneva, will be in Montreal June 22-28 to attend the 14th Quadrennial Congress of the ICN.

Sheila Quinn, ICN executive director. Born in England, she is a nursing graduate from Royal Infirmary, Lancaster, and holds a B.Sc. in Economics from the University of London. She was nurse tutor at Prince of Wales Hospital, London, prior to joining the ICN in 1961. *Marjorie Duvillard, ICN deputy executive director.* Born in Argentina, she attended secondary school and Le Bon Secours school of nursing in Geneva, where she was director prior to her recent appointment to the ICN in 1969. *Martha (Biddy) Shout, ICN nurse advisor.* Born in Great Britain, she is a graduate of Mildmay Memorial Hospital and Metropolitan Hospital, London. Prior to joining ICN in 1966, she was principal nursing tutor and registrar, Nurses Board of Ghana. *Mrs. Margaret Pickard, ICN nurse advisor.* Born in New Zealand, she is a graduate from Wellington Hospital School of Nursing and New Zealand Postgraduate School of Nursing. Prior to joining ICN in 1968, she was national secretary, New Zealand Registered Nurses Association. *Alice Thompson, Editor, International Nursing Review.* Born and educated in England, she was librarian at Royal College of Nursing and National Council of Nurses, London, prior to joining ICN in 1968. *Dr. Mary Seivwright, ICN nurse advisor.* Born in Jamaica, Dr. Seivwright attended Montego Bay and Kingston Public Hospital Schools in Jamaica, and holds a B.Sc., M.A. and Ed.D. from Columbia University. She joined ICN in 1969. *Mrs. Merren Tardivelle, ICN editorial assistant.* Born in Manitoba, she is a graduate of Portage Collegiate Institute, Portage la Prairie, and holds a B.A. from the University of Manitoba. She joined the ICN in 1966 after two years with the League of Red Cross Societies in Geneva. *Christine Redman, ICN congress secretary.* Born and educated in England, she was production assistant at the BBC in London prior to joining ICN in 1968.

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(Continued from page 10)

to the curriculum.

To establish a master's program, long range planning is vital, Dr. Good said. An effective graduate program will not happen overnight; frank and serious evaluation, both internal (including philosophy and purposes) and external (including societal needs and clinical and financial resources), is needed. "You must recognize," Dr. Good said, "that the ultimate purpose is quality education for the practice and/or teaching of nursing."

Students Discuss Pros and Cons Of Own Provincial Association

Toronto, Ont. – The pros and cons of setting up a provincial student nurses' association were discussed in some detail by students attending a special student session at the annual meeting of the Registered Nurses' Association of Ontario in May.

Over 200 students listened as a five-member panel outlined some of the activities of various student groups already established in the province. These groups include the Student Nurses' Association of Windsor, the Toronto Student Nurses' Association, the Eastern Ontario Student Nurses' Association, and the Student Nurses' Association of Southwestern Ontario.

A lively discussion followed, and at least 25 students in the audience presented arguments against or in favor of setting up a provincial, and eventually a national, student association. A major problem, as seen by several students, would be the difficulty in organizing a provincial association in a province as large as Ontario. Finances, too, were seen as an obstacle, as well as the problem of interesting students in an organization of this size. Several speakers believed that efforts should be made to strengthen the groups at the local level before attempting to organize on the provincial level.

An equal number of students spoke in favor of setting up a provincial association as soon as possible, and chastised their colleagues for being apathetic about the idea. One student said that students should have more say in curriculum and examination planning, and that a provincial student nurses' association could conceivably act as a pressure group in effecting change. Another student pointed out that Ontario was the only province without a provincial student nurses' association.

The student delegates approved several resolutions: 1. that RNAO be asked to compile a mailing list of student council presidents in schools of nursing in the province, and that students provide this information annually to RNAO; 2. that the mailing list be distributed to all schools of nursing and student nurses' associations in the province to facilitate communication among students; 3. that the *pro tem* committee already in existence be expanded and be given the responsibility of examining proposals discussed by the students at the RNAO meeting.



Line-up at the microphones. RNAO members wait their turn to express opinions about collective bargaining methods. The discussion centered on resolutions presented on the final day of the RNAO annual meeting held in Toronto in May.



Three of the five student nurse panelists who spoke at a special students' session at the RNAO annual meeting in May. Left to right: Valerie Bassett, president of the Toronto Student Nurses' Association; Michael Roland, chairman of the Student Nurses' Association of Southwestern Ontario; and Carolyn Coates, publicity convener of TSNA.

RNAO Delegates Approve Affiliate Status

Toronto, Ont. – Voting delegates at the annual meeting of the Registered Nurses' Association of Ontario held May 1-3 approved a change in the association's bylaws to permit specific categories of registered nurses to become "affiliates" of the association.

A registered nurse would qualify for this designation if she is: 1. a resident in Ontario and not working in the practice of nursing; 2. a resident outside Ontario, and not working in the province; 3. a full-time postbasic student enrolled at a recognized university. The annual fee for the first category of affiliate and for the "postbasic affiliate" is $18; the fee for the "out-of-province affiliate" is $12.

Unless the bylaws of the association specifically require regular membership standing, affiliates and postbasic student affiliates will be entitled to the rights and privileges of a regular member. An out-of-province affiliate will receive the *RNAO News* and will be allowed to participate in the RNAO income protection plan. However, this affiliate will not otherwise be entitled to any rights or privileges in the association.

The affiliates will not be considered members of RNAO, but affiliates of the association.

A proposed bylaw to permit a graduate nurse who is not a registrant of the College of Nurses of Ontario, but who is a member of a local collective bargaining

(Continued on page 14

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(Continued from page 12)

association to become an "associate" of the RNAO, was defeated. Delegates expressed concern that this category would make it possible for a graduate nurse who had registration revoked by the College to become an associate. Other delegates pointed out that the association is for registered nurses only.

The following resolutions were also approved by the delegates:

- That advertising be included in the *RNAO News* to help offset financial difficulties faced by the association.
- That RNAO recommend to the College of Nurses of Ontario that an optional psychiatric nursing test be made available to candidates writing national tests and to all registered nurses in Ontario. If the test is introduced, the RNAO will assess the results of these options in 1972, and may at that time recommend to the College that the psychiatric nursing test be a requirement for registration in Ontario.
- That RNAO take appropriate steps to modify provincial fiscal policy to permit abolition of the internship year in schools of nursing. Basic nursing education would then be financed in the same way as other post secondary professional educational programs.
- That the RNAO recommend that the 1967 Public Health Act of Ontario Section 1 be amended to include a definition of "Public Health Nurse." There is no definition in the 1967 Act.

Collective bargaining and the methods used by nurses under existing provincial legislation continue to be debatable issues among Ontario nurses. Delegates approved a resolution to allow RNAO to seek legal recognition to represent all nurses in the province at the bargaining table. They defeated a resolution asking for a survey of membership to ascertain the degree of member satisfaction with collective bargaining under the Labour Relations Act.

Delegates also defeated a resolution to recommend that a nurse be appointed as an official member of the Ontario Hospital Services Commission, because they believed that nurses could have more influence on the Commission when not officially a part of it.



RNAO Recommends $7,000 As Minimum Salary For RN

Toronto, Ont. — Delegates at the Registered Nurses' Association of Ontario annual meeting May 1-3 approved a minimum salary of $7,000 for a registered nurse in 1970. This represents a six percent increase over the 1969 recommendation. A registered nurse with university preparation would receive an additional $600 for a diploma, $1,200 for a bachelor's degree, and $1,800 for a master's degree.

Other new standards include:

- at least 11 paid statutory holidays
- at least 24 hours off when tours of duty change
- safe transportation provided by the employer for all female nurses coming on or off duty between 12:00 midnight and 6:00 a.m.
- no loss of salary when a nurse is transferred from one position level to a higher position level
- $33.65 a day for a part-time nurse
- graduates from outside Ontario whose registration is granted without examination to be paid the registered nurse salary retroactive to the date of employment

The Canadian Nurses' Association's 1970 salary goal for the beginning practitioner from a basic diploma nursing program is $7,200 per annum, and for the beginning practitioner from a baccalaureate program, no less than $8,640 per annum.

CNA Representatives Meet With Minister of Health

Ottawa. — Sister Mary Felicitas, pres-

ident of the Canadian Nurses' Association, Dr. Helen K. Mussallem, executive director of CNA, and Mrs. Lois Graham-Cumming, CNA's director of research and advisory services, met for one hour April 25 with the Minister of Health, John Munro, and other federal health officials.

The meeting was arranged to apprise the Minister of the objectives, activities, and concerns of the association and to give him an opportunity to ask questions.

Minister Announces National Nurse Week

Ottawa. – John Munro, Minister of National Health and Welfare, has declared June 22 to 28 "National Nurse Week" in Canada to honor the nursing profession and to mark the 14th Quadrennial Congress of the International Council of Nurses in Montreal.

"On behalf of our country, may I extend our hospitality to our visitors, along with that of the host organization, the Canadian Nurses' Association," he said.

The minister noted the role of nurses in the changing pattern of health care throughout the country, and lauded the contribution Canadian nurses have made to international organizations and technical assistance programs. He termed the congress "an event of importance to the international health community and to Canada."

Mr. Munro will be present at the Congress June 25 to open the plenary sessions.

VON Holds 71st Annual Meeting

Ottawa. – The variety of ways in which the Victorian Order of Nurses for Canada contributed to the health care of Canadians in 1968 was outlined by Jean Leask, director in chief of VON, at the 71st annual meeting May 8-9.

In her report Miss Leask said that more than 109,000 patients had received care from the 104 branches of VON across Canada. The VON is striving to insure continuity of patient care by instituting referral programs; last year 75 branches worked with local hospitals to provide continuing care, Miss Leask explained. She also reported that maternal and child care, night care during acute or terminal illness, and health counseling services for adults and industries were provided by the VON in 1968.

Miss Leask referred to the efforts of VON to adapt its services to meet the changing demands for health services and the delivery of these services.

A project to study the team nursing concept was undertaken by VON in 1968. The report of that study is now in preparation, Miss Leask said.

With the increasing emphasis on rehabilitation and home care, the physiotherapist plays an important role with VON; she not only gives direct patient care but also acts as consultant to nursing personnel.

In 1968 more than 1,500 homes received housekeeping services that have become an important part of home care for some patients, Miss Leask said. In addition, the Hamilton branch of VON reported a successful pilot year with its new "meals on wheels" service that provided over 16,000 meals to 224 persons. This success prompted a similar project in Edmonton that recently got under way.

The national office of VON coordinates activities to reach common standards and goals and is responsible for maintaining the quality and an adequate number of personnel, Miss Leask reported. In 1968 there were 765 registered nurses on staff. Twenty-two percent held baccalaureate or master's degrees and 60 percent had preparation in public health nursing.

Miss Leask believes that it is becoming increasingly important for the public to participate actively in the planning, financing, and delivery of the service they will use. Inherent in the structure of the VON is the partnership between the public and professional health workers. To the presi-

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dent of VON falls the task of providing leadership for both segments of this partnership, Miss Leask explained.

Mrs. C.H.A. Armstrong of Toronto was elected president of the Victorian Order of Nurses for Canada at the opening session May 8, attended by 200 delegates. She has a B.A. degree in modern history from the University of Toronto, and for 10 years wrote a weekly cooking column for the magazine *Saturday Night* under the name Janet March. Mrs. Armstrong, who succeeds Dr. G.D.W. Cameron, is the first woman president of VON since the founder Lady Aberdeen in 1897.

Three new staff members were appointed to national office in September. Eleanor MacDougall is regional director for Alberta and Saskatchewan and Marlene Line and Ruby Cuthbert are regional supervisors.

Index Of Canadian Nursing Studies Available

Ottawa. – The Canadian Nurses' Association has two continuing projects related to Canadian studies on nursing: *the CNA Repository Collection of Nursing Studies* and the *CNA Index of Canadian Nursing Studies.* Both these projects are concerned with studies about nursing in Canada or by Canadian nurses.

A preliminary *Index* was issued in 1964. A revised copy has now been prepared and will be distributed to schools of nursing libraries and research libraries.

The *Index* includes all completed studies to which reference can be found, as well as those in the Repository Collection of Nursing Studies in the CNA Library. Studies in the collection are available for research in the library or on interlibrary loan for faculty or graduate study.

Mature Students To Be Admitted To BC Schools Of Nursing

Victoria, B.C. – Bill 63, an act to amend the Registered Nurses' Act of British Columbia, became effective April 2.

The Act was amended by the provincial government at the request of RNABC to allow post secondary educational institutions, such as regional colleges and technological institutes, to exercise their judgment as to whether the educational background of an applicant is such that he or she can succeed in the nursing program. Under the terms of the amendment, a candidate for admission to a BC school of nursing may be a "mature student without the necessary academic qualifications."

Previously, the minimum educational requirements were: (a) a graduate of a secondary school in an academic-technical program or (b) a graduate of a program certified by the registrar of the Department of Education or the registrar of a post-secondary public educational institution in the province to be equivalent to the qualifications under clause (a).

Although the RNABC cannot legally prevent a university or college from operating any kind of program, Section 13 of the Nurses' Act gives the RNABC the authority to deny registration to a graduate of any nursing program that it has not approved.

Less Paperwork And Bureaucracy If Nursing Is To Survive

Winnipeg, Man. – Non-involvement is a lonely, superficial road, a well-known nurse educator told 300 nurses at the annual meeting of District 1, Manitoba Association of Registered Nurses April 24.

Marguerite Schumacher, director of nursing at Red Deer Junior College in Alberta and first vice-president of the

(Continued on page 18



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news

(Continued from page 16)

Canadian Nurses' Association, said that involvement with patient care means taking risks, but that the end result is worth it, for without involvement one only exists. "Involvement is not haphazard," Miss Schumacher said. "It is caring for and sharing the feelings of the patient as a person. If the nurse really cares, her attitudes and expressions will reflect this care," she told the MARN nurses.

Miss Schumacher warned her audience that nursing must stop revolving around bureaucracy and paperwork, if it is to survive. "Otherwise," she said, "persons with lesser preparation will take over patient care and will do a better job than professional nurses."

Student Nurses Debate Role of the Supervisor

Ottawa. – Is the traditional role of the supervisor no longer relevant to good nursing care?

This question provided an evening of heated debate March 18 by six students in the Certificate Program of Nursing Education at the University of Ottawa.

The three students arguing for the affirmative advocated removing the supervisory level – a role that is "confusing and self-limiting." This role was referred to as a "dichotomy," because of conflicting administrative functions. In place of the "traditional" supervisor, they proposed a reorganization of nursing service to relieve key personnel of non-nursing duties.

This aim was shared by both sides. The three students on the negative, however, argued that changes in attitude toward supervision were required, not removal of the supervisor. They compared this role with a valuable piece of machinery that has not functioned properly and "would not be discarded without first attempting to have it repaired."

The students' preparation for the debate involved interviewing staff members at Ottawa's Civic, General, and Riverside hospitals.

The winning side, chosen by the judges – three Ottawa educators – was the affirmative. Some 100 fellow students and faculty provided an enthusiastic audience.

Harder Bargaining Ahead For Canadian Nurses

Vancouver, B.C. – "As collective bargaining becomes the accepted means of improving salaries and working conditions for nurses across Canada, hospital associations are becoming . . . more united in their efforts to keep nurses in line." This statement was made by M. Louise Tod, employment relations officer for the Alberta Association of Registered Nurses, in an address to 100 nurses from 67 staff groups attending the Registered Nurses' Association of British Columbia's Staff Representatives Conference in the Hotel Vancouver, April 21 and 22.

Miss Tod, who is chairman of the Canadian Nurses' Association's committee on social and economic welfare, predicted harder bargaining ahead for Canadian nurses and said they could no longer work in isolation. She called for greater communication between the provinces to ensure successful collective bargaining programs. Miss Tod said that nurses could not represent nursing effectively in collective bargaining unless they were well informed in the area of nursing service and nursing education. She pointed out that close liaison was needed between provincial staff nurse committees or their equivalents and provincial committees on nursing service and education.

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A Canadian nurse has again been appointed chief nursing officer of the World Health Organization.

Lily M. Turnbull (R.N., Regina General H.; B.N., McGill U.; M.P.H., Johns Hopkins U.) assumed this top nursing position in WHO in April. She replaces Lyle Creelman, who returned to Canada in 1968 after 14 years as WHO chief nursing officer.

Miss Turnbull joined WHO in 1952 after holding head nurse and nursing supervisory positions in Canadian hospitals. Until 1957 she worked in Malaysia as nurse educator, assisting in the development of nursing education programs. From 1957 until her present appointment, Miss Turnbull was regional nursing adviser for the Western Pacific region of WHO.

Two new appointments have been made at St. Paul's Hospital, Vancouver. **Marie Whitney** (B.S.N., U. British Columbia) is assistant director, school of nursing. Before joining the teaching faculty at St. Paul's Hospital, Mrs. Whitney was a clinical instructor in psychiatric nursing at the Provincial Government Education Centre, Riverview Hospital, Essondale, B.C.



Audrey Murray (R.N., Galt H., Lethbridge; B.S.N., U. Washington, Seattle) is director of nursing service. She was formerly assistant director of St. Paul's School of Nursing, and has been at the hospital since 1956.



Margaret A. Motiuk (R.N., Misericordia H., Edmonton; B.N., School for Graduate Nurses, McGill U., Montreal; Dipl. Nurs. Service Admin., U. Saskatchewan) has been appointed assistant director of nursing, Rockyview Hospital, Calgary.

Miss Motiuk has been a head nurse, assistant director, and deputy director of nursing service at the Misericordia Hospital, and a supervisor at the Royal Inland Hospital, Kamloops, B.C.

RNAO Elects New Officers



Albert W. Wedgery, president of the Registered Nurses' Association of Ontario since 1967, gives a few words of advice to the new RNAO officers, Laura E. Butler (left), president, and Josephine Flaherty, president-elect. Over 1,900 RNAO members attended the association's annual meeting in Toronto in May.



Shirley M. Stinson (R.N.; B.Sc.N., U. Alberta; M.N.A., U. Minnesota) has received a dual appointment on the faculty of the University of Alberta, Edmonton, effective July 1. She will be responsible for teaching and research in the School of Health Services Administration and will work in the School of Nursing.

For the past year Miss Stinson has been completing the doctor of education program at Teachers College, Columbia University in New York. She received the Dr. Katherine McLaggan fellowship from the Canadian Nurses' Foundation in 1967.

Miss Stinson was associate director of nursing service at The Hospital for Sick Children, Toronto, from 1961 to 1965. Following this, she was an assistant professor in the University of Alberta School of Nursing.



Mary Jane Seivwright (B.Sc., M.A., Ed.D., Columbia U., New York) has been appointed Nurse Adviser on the staff of the International Council of Nurses.

Dr. Seivwright, a native of Jamaica, has worked as a public health nurse in Kingston, Jamaica, and in Toronto. Her varied nursing experience in New York included work with the Visiting Nurse Service, City Department of Hospitals, nursing supervisor at the Hebrew Hospital for Chronic Sick, chief project nurse at the Albert Einstein College of Medicine, and project director at the Institute of Research, Teachers College, Columbia University.

Irma Butz (R.N., Royal Victoria H., Montreal; degree in public health admin., McGill U.) has been appointed assistant

(Continued on page 22)

New and Recent Books from Collier-Macmillan

The Emergence of Modern Nursing, Second Edition

By Vern L. Bullough, B.A., M.A., Ph.D., Professor of History, San Fernando Valley State College; and Bonnie Bullough, R.N., M.S., M.A., Ph.D., Assistant Professor, School of Nursing, University of California, Los Angeles

The Second Edition of this popular text describes the evolution of modern nursing, with unusual sensitivity to nursing problems of the past and present. Especially interesting is new material on nursing practice in Europe and in the less developed areas of the world. A new bibliographic essay is included. 1969, approx. 288 pages, $7.70

Management of Nursing Care

By Elma L. Rinehart, B.S., M.A., Assistant Director, Nursing Service, Cincinnati General Hospital

Written for *all* members of the nursing team, this book focuses on the patient care unit and explores the possibilities for effective nursing management in the progressive hospital. The author provides an intimate study of the nursing team, with emphasis on the role of the head nurse and the working relationships which contribute to productive nursing. 1969, 243 pages, $7.70

Microbiology in Nursing Practice

By Marion E. Wilson, M.A., Ph.D., Chief Microbiologist, New York City Department of Health, Bureau of Laboratories, and Helen Eckel Mizer, R.N., A.B., M.S., Instructor, Department of Nursing Education, Western Connecticut State College

This comprehensive book provides the practicing or prospective nurse with basic information on the principles of microbiology and the epidemiology of microbial diseases. Nursing applications are consistently emphasized. Excellent illustrations, chapter outlines, bibliographies, and appendices enhance the self-study aspects of the book.
1969, approx. 704 pages, $10.25

The Cardiac Surgical Patient
Pathophysiologic Considerations and Nursing Care

By Maryann E. Powers, B.S., Head Nurse, Cardiac Recovery Room, University of Oregon Medical School Hospital; and Frances Storlie, R.N., M.S., Instructor for Cardiac Care, Nursing Inservice, Providence Hospital, Portland, Oregon

This text is the first *physiological, patient-centered* approach to the cardiac emergencies encountered by medical-surgical nurses. Congenital cardiac defects and acquired cardiac diseases are discussed in terms of physiology, clinical profile, prognosis, and surgical correction.
1969, approx. 256 pages, prob. $8.80

Pharmacology and Therapeutics, Fourth Edition

By Ruth D. Musser, A.B., M.S., formerly Assistant Professor in Pharmacology, School of Medicine, and formerly Chairman of Pharmacology, School of Nursing, University of Maryland, Baltimore, and John J. O'Neill, Ph.D., M.S., B.S., Associate Professor, Department of Cell Biology and Pharmacology, School of Medicine, University of Maryland, Baltimore

In the Fourth Edition of this widely-used text a new co-author adds to the preparation of this book his significant experience in cell biology and related molecular pharmacology. New material is included on drug abuse and control, pituitary hormones, reproduction and contraception, vaccines and serums, water and electrolytes, the management of severe burns, and the use of drugs for diagnostic purposes.
1969, approx. 896 pages, prob. $12.10

Clinical Nursing
Pathophysiological and Psychosocial Approaches

By Irene L. Beland, B.S., M.S., R.N., Professor of Nursing, College of Nursing, Wayne State University

A pioneering book, *Clinical Nursing* is oriented in the sciences—physical, biological, and social—to help the nurse view the patient as a *whole* individual, an individual whose illness is affected by a variety of factors.
1965, 1398 pages, $14.25

Anatomy and Physiology, Fifteenth Edition

By the late Clifford Kimber, the late Carolyn E. Gray, and the late Caroline E. Stackpole; Revised by Lutie C. Leavell, M.A., M.S., Emeritus, Teachers College, Columbia University; and Marjorie A. Miller, M.S., Cornell University; with the assistance of Florence M. Chapin, M.A., M.S., University of Pennsylvania School of Nursing

"This excellent textbook has become a classic....The authors have incorporated all pertinent new material, and have added new tables which help clarify the information....Two distinct improvements are: the placement of discussion of sensations and the sensory organs with the material on the nervous system and adding information on the nerve and blood relations of specific muscles to the discussion of muscles."
—*American Journal of Nursing*
1966, 805 pages, $10.00
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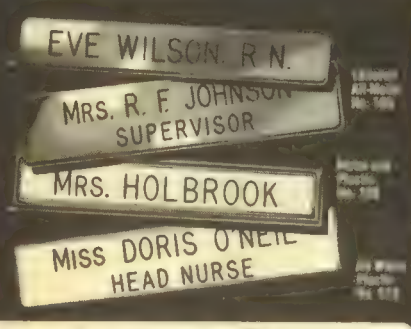
Obstetric Nursing, Fifth Edition

By Erna Ziegel, B.S., M.H., R.N., Associate Professor of Obstetric Nursing, The University of Wisconsin, and the late Carolyn Van Blarcom, A.M.

"The author has been most successful in presenting detailed technical procedures associated with nursing care of mother and infant."
—*American Journal of Nursing*
1964, 795 pages, $9.35

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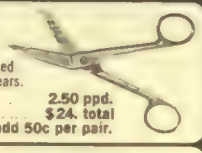
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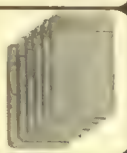
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names

(Continued from page 20)

director of nursing, Douglas Hospital, Verdun, Quebec.

Mrs. Butz was formerly director of nursing education at the Albert Prevost Institute, Montreal.

Gladys Sharpe, who retired last year after 42 years in nursing, received an honorary life membership in the Registered Nurses' Association of Ontario at the RNAO annual meeting in May. The honorary membership was presented to Miss Sharpe "for service to the cause of nursing and the betterment of humanity far beyond the course of duty."

Miss Sharpe, a well-known figure in Canadian nursing, is a past president of the RNAO and the Canadian Nurses' Association.

Ethel Horn, associate professor at the School of Nursing, The University of Western Ontario, was in Scotland in April for a month's study tour of Family Practice Units and Community Mental Health Centers in England and Scotland. On arrival in Scotland she spent several days at the University of Edinburgh in the World Health Organization Research Studies Unit. The tour was supported by a research travel grant from the Ivey Foundation.



Jean W. Forrest (Reg.N., Toronto General H.; B.N., McGill U.; B.A., Laurentian U., Sudbury; M.S., Boston U.) has been appointed assistant professor of the School of Nursing, The University of Western Ontario.

Miss Forrest has had extensive experience in public health nursing in Ontario, most recently as a supervisor with the Sudbury and District Health Unit.

Dorothy E. Rajcsanyi (R.N., Montreal General H.; Dipl. P.H., McGill U.; B.N., McGill U.) has been named associate director in charge of education, Victorian Order of Nurses, Greater Montreal branch.

Mrs. Rajcsanyi, a native of Montreal, has been on the nursing staff of The Montreal General Hospital. Her experience with the Montreal branch of the VON has included administrative work; she has been VON liaison for the Royal Victoria and Jewish General Hospitals. □



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St. Michael's Hospital, Toronto, pp. 46, 47

dates

June 9-20, 1969
Two-week seminar for senior nursing executives, School of Nursing, University of Western Ontario, London. Fee with residence – $250; without residence – $125.

June 11, 1969
Reunion of graduates and friends of Guy's Hospital, London, England, Royal York Hotel, Toronto, 5 p.m. Further information may be obtained from the Canadian Tuberculosis Association, 343 O'Connor Street, Ottawa.

June 11-14, 1969
19th annual meeting of the Canadian Psychiatric Association, King Edward Hotel, Toronto. A $5 registration fee for non-members must be paid in advance to The Montreal Children's Hospital, Dept. of Psychiatry, and should be sent to: Dr. K. Mende, Dept. of Psychiatry, The Montreal Children's Hospital, 2300 Tupper St., Montreal 108.

June 13, 1969
Ophthalmic Assistants' Association of Ontario Symposium, Royal York Hotel, Toronto.

June 18-20, 1969
Conference on pediatric nursing, The Hospital for Sick Children, Toronto.

June 19-20, 1969
Two-day program for nurse educators, McMaster University School of Nursing, Hamilton.

June 24, 1969
Meeting of nurses interested in continuing education, McGill University, School for Graduate Nurses, Montreal.

June 9-13, 16-20, 1969
June 30 - July 4, 1969
Registered Nurses' Association of Ontario programs for visitors to the Congress of the International Council of Nurses. Symposiums on nursing service, public health, and nursing education, with visits to cooperating hospitals and health agencies.

July 3 - August 15, 1969
Six-week course for ophthalmic assistants, Centennial College of Applied Arts and Technology, 1651 Warden Ave., Scarborough, Ont. Fee: $75. Candidates must be sponsored by an ophthalmologist.

August 1968 - June 1969
The National League for Nursing is sponsoring a series of 12 two-day workshops in several U.S. cities for persons involved in administration, planning, and evaluation of hospital nursing services. The first workshop was held in San Francisco August 9, 1968, and the last will be held in Miami Beach, June 26-27, 1969.

The workshops are designed for nurses and others interested in nursing audits, new staffing patterns, and hospital staff development programs.

Further information and application forms for registration may be obtained from the Department of Hospital Nursing, National League for Nursing, 10 Columbus Circle, New York, New York 10019.

September 18-20, 1969
Annual conference on obstetrics, gynecologic, and neonatal nursing, Sheraton-Brock Hotel, Niagara Falls, Ontario. Sponsored by District V of the American College of Obstetricians and Gynecologists.

September 23-25, 1969
10th annual meeting and convention of Associated Nursing Homes, Inc., Sheraton-Connaught Hotel, Hamilton.

September 25-27, 1969
3rd annual postgraduate course for emergency room nurses, Palmer House Hotel, Chicago. Tuition fee: $60. Write to: Dr. Anast, 55 East Washington Street, Chicago, Illinois 60602.

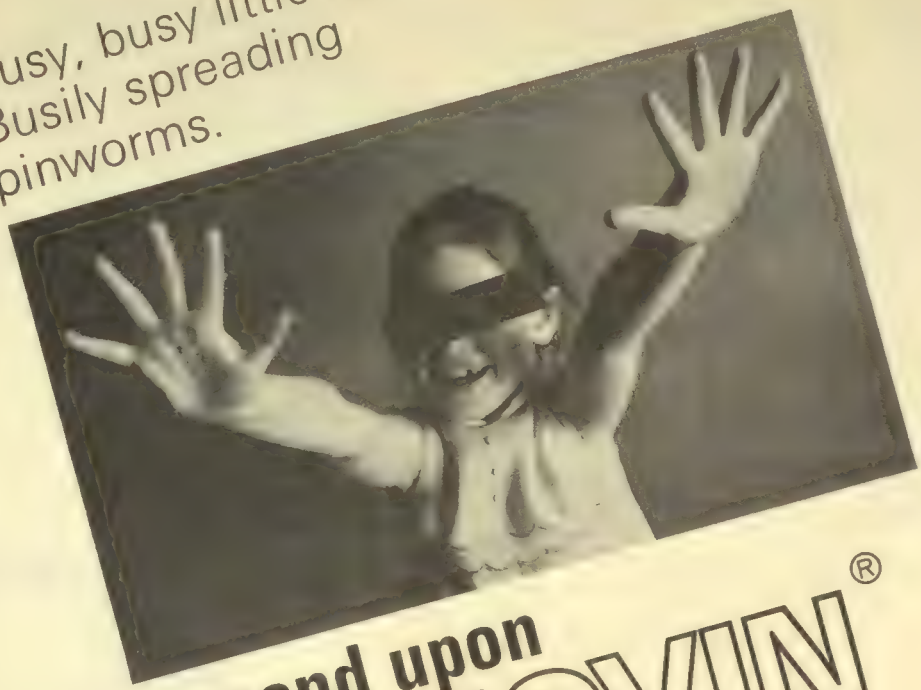
September 28 - October 3, 1969
13th annual Registered Nurses' Association of Ontario Conference on personal growth and group achievement, Delawana Inn, Honey Harbour.

October 6-8, 1969
Annual conference on obstetrical and gynecological nursing, sponsored by District VI of the American College of Obstetricans and Gynecologists. To be held in the Marlborough Hotel, Winnipeg. Nurses from all over Canada are welcome.

October 24, 1969
Catholic Hospital Conference of Ontario Nursing Committee meeting, Westbury Hotel, Toronto.

October 27-28, 1969
Ontario Hospital Association 45th annual convention, Royal York Hotel, Toronto.

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References: 1. Beck, J.W., Saavedra, D., Antell, G.J., and Tejeiro, B.: Am. J. Trop. Med. **8**:349, 1959. 2. Sanders, A.I., and Hall, W.H.: J. Lab. & Clin. Med. **56**:413, 1960.

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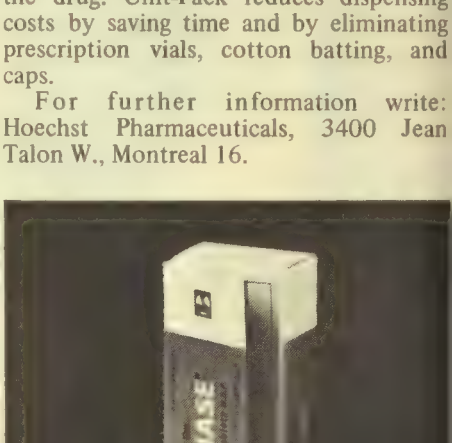
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in a capsule

Black Friday

"Oh no," was one of the milder reactions of *The Canadian Nurse* editorial staff when Whoo-fur, the white, furry mascot of the ICN Congress, returned from the printer with a black beard (News, May 1969, page 9).

What had our former blonde done to deserve such treatment? It just shows that you never know how dangerous a trip to the printer can be!

Poor Whoo-fur. We're all waiting to see the real you in Montreal.

Nurses make high-status marriages

A study conducted by two American sociologists has found that girls from low-status families who become nurses are much more likely to marry men of high status than are girls who do not enter nursing.

According to the study, reported in *Nursing Times,* this applies whether the girls are college-educated or not.

Although girls from rural communities were found less likely to marry high-status men than were urban girls, the rural girls' chances increased if they became nurses.

Child's-eye view of surgery

The *Grey Vine,* published by the Regina Grey Nuns' Hospital, recently wrote about the following nurse's experience.

"In my years of nursing I thought I had seen every item that a patient could bring to the hospital. But a paper cup filled with dirt, brought by a little girl facing major surgery, had me mystified. The child had been ill for several years and I wondered if she still had the spirit she would need during the next few days. My doubts vanished as she explained, "That's the bean I planted before I came. We're going to have a race to see who gets his head up first."

Surgery was successful, and she beat the bean."

Relatives found

For two Australian sisters — an assistant nursing matron and a hospital business administrator — the 14th Quadrennial Congress of the International Council of Nurses will be an extra special event.

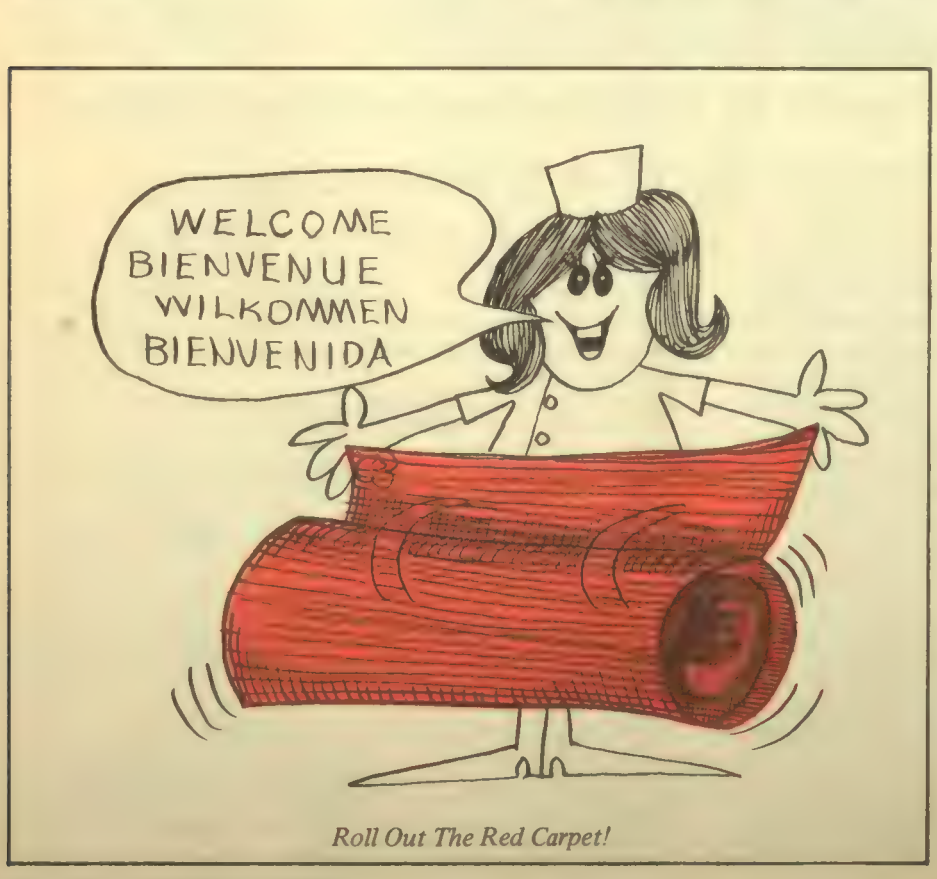
The long trip from Joondanna, Western Australia, to Montreal will be their first to Canada. The emotional part of the journey, however, will be their visit to Toronto following the congress.

In January, Miss Elaine Greger wrote to the Canadian Red Cross national headquarters and made a special request. She sought help in locating her aging mother's relatives with whom the family had lost contact in Canada 25 years ago. Over the years a series of letters to Toronto addresses had been returned with the disappointing marking, "Moved, left no address."

Dr. Helen G. McArthur, national director of Red Cross nursing services, took a special interest in the case. On receipt of the request, the Enquiry Bureau took up the search. Within a few days, Toronto-Central Branch had reached the relatives. The Toronto relatives plan a happy reunion this summer for the two delegates from down under.

Wear maple leaf at ICN

A well-traveled nurse from Toronto A. Cecilia Pope, has suggested a good way for us to identify ourselves as Canadian nurses at the ICN Congress: wear a maple leaf pin, and perhaps give one to a visitor as a distinctive Canadian souvenir.



Roll Out The Red Carpet!

The nose knows?

Osmics is becoming big business, because of man's extraordinary sense of smell.

This finding is explained in a speech reported in the April *Ontario Newsletter* published by the Consumers Association of Canada.

According to the vice-president in charge of market planning for Mattel Inc., marketing should encourage a customer to: open bags of freshly roasted coffee, packages of linens and towels with the "clean wash smell" built into the package, and packaged grass seed that smells like freshly cut grass. Marketers are already wrapping bread in waxed paper impregnated with "freshly baked" odor, wafting synthetic strawberry scents over the frozen strawberry section of the supermarket, impregnating nylon rope with the odor of tarred hemp, putting the scent of cheddar cheese on mousetraps and — unfortunately — blending banana oil, glue, leather, rubber, gasoline and plastic to make a "new car smell," which can be hidden behind the seat of "back row beauty."

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In the first part of the book, Mrs. Sutton describes the basic techniques that are common to all areas of clinical nursing. Then she takes up the more specialized techniques used in disorders of each of the body systems. This arrangement provides a natural division that corresponds to that of the nursing specialties. Each of these chapters is subdivided under such headings as Diagnostic Procedures, Therapeutic and Rehabilitative Procedures, Additional Procedures to Review, Diets to Review, and Medications to Review.

Nurses by the tens of thousands have found *"Sutton"* unparalleled as a source of current information. It is ideal for the recent graduate who seeks help on how to perform specific clinical techniques... for the nurse returning to practice after an interruption... for the nurse who wants to transfer from one area of practice to another. Order your copy now!

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1398 pages. 871 line drawings. $8.95. Published March, 1969.

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GUEST EDITORIAL

International forum in Montreal

Sheila Quinn

It would be interesting to know if any of the founder members of the International Council of Nurses had a vision of the great organization they had set in motion when they first put forward the "international idea" in 1899, and gathered for the first Congress in Buffalo, New York, in 1901. If they could be present in Concordia Hall in Montreal this June, would they recognize ICN as it is today, and would they feel it is meeting the needs or fulfilling the purposes for which it was intended?

In 1901, travel to Buffalo was slow and costly. Sixty-eight years later, nurses from more than 70 countries who converge on Montreal will still find it costly. But even in these days of space travel, there is still something exciting about the way in which thousands of nurses come together so quickly, and as rapidly scatter again to the four quarters of the globe. Whatever else those early nurses might think of ICN as it is today, they would agree that it is fulfilling magnificently one of its primary objectives of providing an international forum for nursing.

Several major issues, based on problems facing the profession and their possible solutions, will be discussed at the business sessions of the 14th Quadrennial Congress. Since these issues affect all nurses, we hope that these sessions will be well attended.

Decision-making can be a lengthy process, even at local and national levels. Nurses are often accused of being a conservative profession, but do other international bodies, even intergovernmental ones, move any faster? True, the question of auxiliary nursing personnel was under discussion at the Stockholm Congress in 1949, and 20 years later it is again on the agenda.

There is, however, a change of emphasis. We are beginning to talk in terms of a "second level nurse," prepared in a definite way and awarded a certificate or other recognition on completion. We are also talking about this person in relation to his or her national association. When the Royal College of Nursing and the National Council of Nurses of the United Kingdom raised the subject of the second level nurse" at the last meeting of the ICN Council of National Representatives (CNR) in 1967, the delegate spoke of "the position of the enrolled nurse *internationally*." It is a burning question, and one on which there will be much discussion relating to the care of the patient and the quality of this care. The profession must think and act wisely for the future.

One of the features of recent years has been the formation of regional groups of national nurses' associations. This could be a trend of the future. We need to assess the relationship of such groups to ICN, and the future role of international, regional, and national associations.

In the future, ICN will become increasingly concerned with all aspects of legislation, since sound legislation is the basis for both preparation of the nurse and quality patient care; without it, nursing education and practice are threatened. The document *Principles of Legislation for Nursing Education and Practice, A Guide to Assist National Nurses' Associations* is the first part of a project undertaken with funds from the Florence Nightingale International Foundation Trust, administered by ICN. Plans are now being made for an international seminar based on this document.

Mention the International Labor Organization (ILO) and nurses, and most people immediately think of the 10-year-old report *Employment and Conditions of Work of Nurses.* But a new project is underway. In 1967 the CNR asked the ILO to consider, with World Health Organization cooperation, the preparation of an international instrument on the status of nurses for the improvement of nursing services. The CNR will be brought up-to-date with the progress of ICN's efforts in this respect. For several years discussion on ICN's relations with ILO has brought conflicting opinions, but the importance of this relationship is becoming more evident. Such an instrument could have a lasting influence on the continuing development of the nursing profession.

Miss Quinn is Executive Director of the International Council of Nurses, Geneva, Switzerland.

The "right to strike" is guaranteed to have every ICN delegate on her feet. This issue was under fire in 1967, at which time the ICN Professional Services Committee was asked to study the possibility of preparing guidelines on economic welfare. This committee has been working with the executive staff throughout the quadrennium on statements in the major areas of nursing education, service, and social and economic welfare of nurses. Any professional association should be able to set down its philosophy on these vital areas. Statements from ICN would not be only a statement of its own beliefs, but also could give leadership and inspiration to many small and developing nurses' associations throughout the world.

The popular and much used ICN Exchange of Privileges Programmes for nurses has been under careful scrutiny, and suggestions will be put forward for revision at the 14th Quadrennial Congress in June. This program, now 20 years old, has helped many nurses to travel abroad, putting their professional qualifications to good use, and giving them valuable experience for use in their own countries. Times change, so do the needs of ICN member associations; ICN programs must adapt to meet these needs.

Every nurse in Montreal should be thinking in the future tense. We will not find all the solutions; many things will remain in discussion until the next meeting, and others may drop and lie fallow for several years until they become a matter of urgency to the profession. Each participant at the Congress will see a world turned – slowly, perhaps imperceptibly, but positively.

A Congress is not just a means of coming together, of meeting old friends, making new ones, and traveling to a new country. It is an international forum that can have a resounding effect throughout the world. If the minds of participants are not stretched to new dimensions, then ICN could be said to be losing its role in the world of today. We dare to prophesy that the "international idea" expressed by Mrs. Bedford Fenwick in 1899 will become reality for many thousands of nurses in June 1969 in Montreal. □

The growth and development of a profession

The 14th Quadrennial Congress of the ICN in Montreal will be yet another landmark in the history of international nursing. The question is: "Where do we go from here?" We are moving faster and faster toward unknown horizons and a future dimly seen. We cannot stop the trend.

Daisy C. Bridges

"Every nurse should give her support to the work of the International Council of Nurses and use all the influence she can command to make this body an instrument of a world community and *not a mere device for calling pleasant conferences.*" These words were spoken, not by a member of the ICN, not even by a nurse, but by a member of a university faculty. He was addressing a meeting of nurses on the subject "The nurse as citizen." The words are singularly apt since an ICN Congress, with Canada as hostess, is once more approaching. Interest in the Council is always more apparent when such plans are in progress. It should be remembered, however, that this is only *one* of ICN's activities. Much routine work is carried on from headquarters during the intervening years.

In the beginning

In a short article it is difficult to do justice to the story of an international organization whose origin dates back to a previous century. Nurses can feel justifiably proud that their profession has been organized internationally longer than any other professional group. A British general addressing his troops once said: "A collection of soldiers is no more an army than a collection of bricks is a house." The same could be said of nurses. Individually they may do good work, but organization is needed to ensure that the best service is offered to the community. Our pioneers foresaw that a profession organized was a profession strengthened; that nurses as individuals could never accomplish what they were capable of doing as a unified body.

The idea of an international nursing organization was first conceived by Mrs. Ethel Gordon Fenwick. In 1899 she proposed the foundation of a federation composed of "nursing councils" from every country. She visualized that this federation would unite the profession in its demands for necessary reform and would help to establish nursing councils in countries that had no form of nursing organization. Mrs. Fenwick's proposal was addressed to a meeting of the Matron's Council of Great Britain. It took the form of a simple resolution: "That steps be taken to organize an International Council of Nurses."

It is probable that no more far-reaching decision has ever been made at any meeting of nurses. Nursing leaders from Australia, Canada, Denmark, Holland, New Zealand, South Africa, and the USA joined with those from Great Britain in forming a provisional international committee to draw up a draft constitution that eventually signalled the birth of the ICN. Under this constitution, which was formally accepted in 1900, with revisions and amendments from time to time, the Council has developed its work and widened its influence through succeeding years.

The objectives of the ICN are simple and have remained unchanged:

- To help in maintaining the highest standards of nursing in member countries
- To assist nurses in countries where there is no association, or where the association is not yet ready for membership, to achieve a form of organization that would enable it to join.

There is another objective, which although not included in the formal constitution, is equally important – the promotion of friendship and fellowship among the nurses of the world. Throughout more than half a century this spirit of international cooperation has been built up. It is a priceless heritage to be cherished and handed on to succeeding generations, and it is our contribution, as nurses, to the cause of world peace.

Throughout its long history, the routine work of the ICN has been carried on from headquarters temporarily located in a number of cities. From 1900 to 1923, Lavinia Lloyd Dock of the USA the ICN honorary secretary, travelled

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Miss Bridges, who was executive secretary of the ICN from 1948 to 1961, is a distinguished world nursing leader. In 1954, she was awarded the decoration of Commander of the Order of the British Empire by Queen Elizabeth. The Canadian Nurses' Association awarded an honorary membership to Miss Bridges in 1958. A recent accomplishment (1967) is her book: *A History of the International Council of Nurses 1899-1964; the first sixty-five years.*

between New York and London maintaining, first from one side of the Atlantic and then from the other, a close relationship with nurses in all countries where there was interest in supporting the new federation.

From 1900 to 1904, Mary Agnes Snively (at that time Lady Superintendent of the Toronto General Hospital) held the office of honorary treasurer. In 1901 she presented what was described as "a very satisfactory balance sheet." The cash balance, when all expenses had been paid, amounted to $14.18.

In 1925 the first permanent headquarters was established in Geneva. Here, the first executive secretary, Christiane Reimann of Denmark, placed the work of the Council on a firm footing. She was succeeded in 1934 by Anna Schwarzenberg of Austria. In 1937 headquarters moved from Geneva to London. Following the outbreak of war in 1939, all essential documents were transferred to the USA. As much work as circumstances permitted under war conditions was carried on, first in New Haven and later in New York. During these difficult years the Canadian Nurses' Association was one of the few member associations with which the ICN president, Effie J. Taylor, could continue to correspond. This contact was a source of great support and encouragement to her.

In 1941, Miss Taylor had written to all member associations, recording the death of Jean Gunn, Lady Superintendent of the Toronto General Hospital, who had been first vice-president of the ICN since 1937. The president wrote: "Few of our members have occupied so deep a place in the hearts of international nurses as Jean Gunn; her name will be placed among those to be remembered always as outstanding figures in international nursing."

In 1948 headquarters returned once again to London. After six years of war, the staff were faced with many difficulties. Temporary offices were found in a bomb-damaged building with broken windows and cracked walls. Total office furniture and equipment consisted, at first, of two tables, a few chairs (on loan), and a portable typewriter brought from



The founder of ICN – Mrs. Bedford Fenwick – seen in center of photo, taken in 1933 in the Royal Palace Grounds, Brussels. Front row, left to right: Mlle Chaptal, president, ICN; Queen Elizabeth of Belgium; and Mrs. Fenwick.



Mary Agnes Snively: a Canadian nurse who held the office of ICN honorary treasurer from 1900 to 1904.



Ethel Gordon Fenwick – who proposed the creation of ICN in 1899.



Effie J. Taylor – a U.S. nurse who was ICN president from 1937 to 1947.



Jean Gunn: first vice-president of ICN from 1937 to 1941.

New York and damaged in transit. Finally, when repairs and decorations were completed, the offices were accommodated on three floors. A further move took place in 1956 and the headquarters finally had "a house and home of its own." Here, in a new building situated in the most historical part of London, the work continued to grow and expand. In 1948 Daisy Bridges of Great Britain succeeded Anna Schwarzenberg as executive (later general) secretary. In 1961 Helen Nussbaum of Switzerland took over the office.

When the 13th Quadrennial Congress was held in Frankfurt in 1965, the question of a future location for ICN Headquarters was again discussed. This gave rise to the following recommendation: "That in the interest of providing the continued effectiveness and development of headquarters' services to member associations, and to the nursing profession throughout the world, more commodious and suitable premises must be obtained."

This recommendation was accepted by the majority of member associations present. Accordingly, headquarters returned once more to Geneva where, since 1966, it has been established in a new office building. The accommodation is spacious and dignified. Under the direction of Sheila Quinn, who succeeded Helen Nussbaum as general secretary, (later executive director) the staff carry on the routine work and meet many and varied demands for assistance.

A moment of climax

It can truly be said that the foundation of the Council was the culminating professional event of a century that had seen the rise of nursing from "suitable employment for women in the lowest class" to an honorable and scientific profession for persons of education and culture. The establishment of nursing schools, the advent of the "trained nurse" as a product of these schools, a growing insistence on educational reform, and the registration of nurses to safeguard the community – these were some of the legacies of the nineteenth century to the twentieth.

The increasing impetus toward professional organization, both national and international, was an inevitable consequence of progress in nursing and a growing consciousness of its obligations to the community. In all these developments the ICN has been in the forefront. It has witnessed the rapid growth of national nursing organizations, infusing the whole profession with strength and vitality; the gradual recognition by government of its responsibility for the preparation of nurses; the development of advanced programs of professional education designed to prepare and equip nurses for administration, teaching, and all spheres of leadership; the advancement of knowledge and understanding of the social implications of all sickness, mental and physical; the greater consciousness of the profession's obligations in the work of preventive medicine; and the need for an international standard of nursing service and nursing education, and a code of ethics pertaining to both.

In 1948 the ICN was admitted into official relationship with the World Health Organization. It was thus recognized as a body capable of representing the views and furthering the purposes of professional nursing throughout the world. Friendly relations with all international organizations in the fields of health and social welfare have conferred on ICN both privileges and responsibilities. These are the rewards for the vision and foresight of our founders, and the climax of more than half a century of progress in nursing service and professional organization.

Milestones and landmarks

At every Congress, plans have been initiated and decisions made that have anticipated and precipitated events, later recognized as landmarks of progress. The names of the cities of Buffalo, Berlin, London, Cologne, Copenhagen, Helsinki, Montreal, Paris, Brussels, Atlantic City, Stockholm, Petropolis, Rome, Melbourne, Frankfurt – have become monuments to nursing achievements that have been the result of perseverance and united action. Only the future will show what outstanding event in nursing history owes its inspiration and impetus to the 14th Quadrennial Congress to be held in Montreal in June, 1969.

In 1901, nurses gathered in Buffalo for the first Congress of the International Council of Nurses. Here is a description of the scene: "Delegates surrounded the President, all in most tasteful toilettes. In the auditorium and gallery were over 400 bright-faced eager women, bristling with energy and expectation." In her closing address, Mrs. Fenwick said: "The time has come when nurses need their educational schools, their endowed colleges, their Chairs of Nursing, their University degrees and State Registration." Inspired words indeed when they were uttered in 1901!

This year many thousands of nurses will gather in Montreal. There is no doubt that we shall listen to pronouncements as inspiring and as far-reaching to guide us through the next half century. At the same time we shall be obeying the command contained in an old Sanscrit proverb: "Walk together, talk together all ye peoples of the earth; then and only then, will ye have peace."

Nursing in Japan

Japanese nurses have the same goals as Canadian nurses and seem to be faced with similar problems.

Sada Nagano

Japan is a country with four main islands in the north-eastern extremity of Asia, with an area slightly smaller than the State of California. The country is 370,000 km. wide and has a population of over 100 million; it is divided into 46 prefectures (districts), and Tokyo is the capital.

History of nursing

The midwife, known as the "birth attendant," was the first nurse to appear on the scene in Japan, around the 17th century. The independent regulation of midwifery was established in 1899, 25 years after the enforcement of the medical system.

Around 1880, several schools of nursing were established by foreign nurses. These schools were the Sakurai Girls' School in Tokyo; the Tokyo Kyoritsu Hospital Nursing School; the Doshisha Nursing School; and the Tokyo Imperial University Hospital Nursing School. Unfortunately, these nursing schools were dissolved within a short time.

From 1917 to 1947, the educational requirement for admission to a nursing school was six years of elementary education, plus two years junior high school. During this time, nurses earned certificates as nurses, midwives, or public health nurses after graduating from an approved training school or after one year of practice and the successful completion of separate perfectural examinations in each category.

The Public Health Nurse Midwife and Nurse Law was passed in 1948. This law, administered by the Ministry of Health and Welfare, prescribes the qualifications, training, practice, registration requirements, national examination, and status for both nurses and assistant nurses.

The Nursing Section, Medical Affairs Bureau of The Ministry of Health and Welfare, is responsible for general control and supervision of nursing affairs including the regulation of supply and demand of nurses, the keeping of statistics, the provision of scholarships and money for the construction and maintenance of nursing schools. The budget of the Nursing Section in the 1969 fiscal year (April 1969–March 1970) will be 275 million yen – approximately $763,888.

At the national level, the Nursing Section assists the 69-member nursing council. The council approves schools of nursing, prepares the national examination, and authorizes the practice of public health nurses, midwives, and nurses.

Nursing service

The demand for an increasing number of nursing personnel comes from all areas of medical services, especially from hospitals. A standard number of nursing personnel for each hospital was established by the Medical Service Law, enacted in 1948, which states as a requirement: "Every 4 inpatients to one nurse and every 30 outpatients to one nurse and add one for any fraction beyond." According to this standard figure, there was a shortage of 31,800 hospital nurses in 1967.

One reason for the shortage of nurses in the past has been the regulations affecting night duty. In 1965, three years after the Government Medical Workers' Union took action, the National Personnel Authority recommended that conditions of nurses' night duties at the national hospitals be improved. The improvements included: 1. no more than eight days a month on night duty; 2. no more single night duty within a nursing unit; 3. a period of six months free of night duty for any nurse who has given birth to a baby – this is in addition to the Labour Standards Law that permits vacation with pay for six weeks before and six weeks following delivery; 4. a clear explanation of "rest hour" and "recess hours." With these improvements, it is hoped that the shortage of nurses will soon be reduced.

Professional associations

There are recognized professional

Mrs. Sada Nagano is Chief of the Nursing Section, Medical Affairs Bureau, Ministry of Health and Welfare, Tokyo, Japan.

nurses' and midwives' organizations in Japan, both incorporated associations. The Japanese Nursing Association has more than 110,000 members, including 12,000 public health nurses, 3,000 midwives, and 95,000 clinical nurses, of whom 40,000 are assistant nurses. The Japan Midwife Association has a membership of 35,000. The President is also a member of the House of Councillors (similar to the Senate in the US Congress).

Conclusion

To meet the need, in quantity and quality, for nursing personnel in the future, the Nursing Section and the entire Medical Affairs Bureau are reexamining the supply and demand for the next 10 years, and are formulating policies to recruit more nursing students and to train larger numbers of nurses. Plans will be made to reduce the attrition rate in nursing, and to attract unemployed nurses back to nursing. □











Top left: a street scene in Tokyo, Japan.

Bottom left: "danchi," or apartment areas, are now being erected on the outskirts of towns. In such a community of apartment residents, most middle-income housewives share common interests and pleasures.

Top right: great progress has been made to bring the benefits of modern medical developments to all. Under various welfare programs, nearly every Japanese is able to receive medical treatment free or at a reasonable charge.

Middle right: a Japanese housewife in front of her home.

Bottom right: Supermarkets are relatively new in Japan, but their appearance has won wide popularity with housewives. Many modern supermarkets, like the one pictured here, can now be found in the large cities of Japan.

Nursing in Colombia

Colombia, similar to other developing countries, faces the problem of providing quality nursing care with limited nursing personnel.

Lucia A. Restrepo, M.S.N., and Elvia C. de Garzon

Colombia is a republic on the northwest coast of South America. Most of its 17 million inhabitants live in the interior cities, isolated from the coast by ranges of mountains. The country is divided into 16 departments, similar to provinces, and each department has its own capital.

In recent years, Colombia has suffered from an alarming shortage of nurses. The most recent information on the nursing situation is reported in the 1965 *Study of Human Resources for Health and Medical Education in Colombia.*[1] Although the figures have changed in the past four years, they give an idea of the nursing resources in Colombia for that period. The ratio to population in the capitals was 22.5 nurses per 100,000 inhabitants (1:444), in contrast to the rest of the country where the ratio was 1.5 nurses per 100,000 inhabitants (1:6667).

Nursing personnel

There are two types of personnel giving nursing care in Colombia: professional nurses and auxiliary personnel. University schools of nursing, established in 1903, provide basic education for nurses — a great benefit to the advancement of nursing in Colombia. Faculty and graduates from the six schools, although small in number, are well prepared.

In 1963 the admission requirements for students to all nursing schools were consolidated and included high school completion. The academic university system was adopted, placing nursing students on the same level, and giving them the same privileges, as students in other faculties within the university. The nursing program was extended to four years to grant the degree of Licentiate in Nursing Sciences.

Study plans were modified to provide students with opportunities to acquire knowledge in the natural and social sciences and the humanities. Theoretical as well as practical experience is provided in administration, supervision, and teaching.

Nursing education in the past stressed the development of skills for bedside care. Graduates, however, were required to occupy supervisory or teaching positions — a situation that compelled nursing educators to consider the need for a new orientation in basic studies. Facts concerning this reorientation were presented by the members of the National Association of Nurses of Colombia, Section of Cundinamarca in 1967.[2]

With these changes in the basic education, supplementary programs were initiated to allow general nurses (graduates of three-year programs) to continue their studies and to obtain the degree of Licentiate in Nursing Sciences. A high percentage of nurses returned to university to undertake these studies, despite the great effort and expense involved.

In an effort to prepare more capable nursing auxiliaries to help relieve the nursing shortage, the Ministry of Public Health provided financial assistance and scholarships to students in the 30 schools for nursing auxiliaries. Approximately 900 graduate each year, and are then required to work in Colombian health institutions. Between 1915 and 1965 there were 3,957 nursing auxiliaries. However, there is no information available on the general characteristics of age, sex, civil status, inactivity, or geographical distribution.

A problem must be faced

The general opinion among Colombian nurses seems to be that there should be only these two types of nursing workers. This avoids fragmentation in patient care, as well as the confusion that arises among the public, medical personnel, and nurses themselves when there are too many types of personnel. Other countries have experienced this problem when there is a proliferation of personnel.

Nevertheless, Colombia, similar to other developing countries, has and will probably continue to use for some time the nursing aide, even though her role in the overall system has not yet been

Miss de Garzon and Miss Restrepo, each hold the Licentiate in Nursing Sciences from the National University, Bogota, D.E., Colombia. Currently, they are assistant professors, Faculty of Nursing, National University of Colombia.

studied in detail. The main reason is economical: patient care given by the nursing aide is less costly. There is growing belief among administrators of health services that nursing aides should be trained and supervised directly by nurses.

The creation of a new type of nurse to relieve the shortage has been suggested. However, the paper presented before the Third National Congress of Nurses in 1967 outlined in detail the economic and administrative aspects that impede the creation of a new type of nursing personnel. [3] More difficulties than solutions would arise.

Where the nurses are

In 1965 there were 1,616 professional nurses in Colombia, of whom 1,177 (72.8 percent) were actively practicing in the country. Lay nurses constituted 77.3 percent and religious nurses 22.7 percent. One hundred and three (6.5 percent) of Colombia's nurses were attracted to other countries by better employment opportunities, opportunities to study, and religious orders. The remaining 336, constituting the group of inactive nurses, had left the profession because of marriage or other personal reasons. More nurses were practicing in the departmental capitals than in the rest of the country.

The data in the *Study* also showed that the official (government controlled) hospitals and the semi-official (religious order) hospitals employed 41.7 percent of the active nurses. The social security institutions employed a considerably smaller proportion, more or less equal to the private sector. About one-half of the remaining nurses were employed in university teaching, the other half, in public health service.

Although the number of nurses has increased in the past few years, the Ministry of Public Health plans to provide more nurses for the rural areas through better work incentives for health professionals in these areas.

Continuing education

The faculty of nursing of the National University has developed programs of continuing education in psychiatry, administration of nursing services, and public health nursing. The nursing school of the University of el Valle offers courses for specialization in psychiatry and in maternal-child health. The faculty of the Javeriana University has undertaken courses in nursing equipment and leadership.

Graduate education is a project that shows many possibilities for realization, once well-qualified nurse teachers are available, and the necessary arrangements that permit the development, continuity, and evaluation of these programs have been made.



A general view of Bogota, Colombia.

The University of el Valle offers programs of graduate education for nurses by means of a provisional licence. This is a temporary measure and will probably be phased out when the masters' programs in the country are officially organized and the minimum requirements for this type of nursing program are determined. Since 1965, courses have been offered in psychiatric nursing, medical and surgical nursing, and maternal and child health nursing. The National and Antioquia Universities are planning masters' programs for nurses occupying positions in teaching and administration. In the future these programs will help solve the shortage of highly qualified teaching personnel, in Colombia as well as in other Latin American countries. For economic and language reasons Colombian nurses cannot take advantage of these studies in other countries.

Perspectives for the future

Basic nursing education has developed positively and rapidly during the past few years, offering new perspectives for Colombian nurses and for nurses coming from other countries of Latin America.

We believe that our efforts must concentrate on strengthening these basic programs, endeavoring constantly to improve the preparation of nurse teachers. In future we plan to: establish new programs of continuing education; raise the scholastic requirements for candidates entering the schools for nursing auxiliaries in such a way that the preparation gap between the registered and the auxiliary nurse is



A main street in Colombia.

narrowed; improve the quality of instruction received by the auxiliary nurse so that she is able to carry out effectively her functions in the health institutions; carry out research studies to determine the functions of the two types of nursing personnel, the actual and future demands of such personnel, and the means of supplying these.

Professional associations

Colombian nurses belong to one of six branches of the Asociación Nacional de Enfermeras de Colombia (ANEC). ANEC is a member of the International Council of Nurses and the Federation of Professionals of Colombia, FEDERPROCOL. The Association publishes a magazine for members, called *ANEC*, through which the nurses receive information and express their opinions and ideas on various professional topics.

The Permanent Committee on Nursing is part of the Colombian Institute for Advancement of Superior Education, formerly the Colombian Association of Universities —National University Fund. It is composed of directors of nursing schools and representatives of the main nursing sectors in the country. It has performed important work in the preparation of standards for the accreditation of university programs, description of the role of the registered nurse, and characteristics of the licentiate programs.

Conclusion

The development of nursing in Colombia has been aided by members of the nursing profession who are motivated to change and to effect change. Various international organizations, such as the World Health Organization, W.K. Kellogg Foundation, the Agency for International Development, the Rockefeller Foundation, and other institutions have provided valuable and efficient assistance. In addition, universities have made a continuous and organized effort to study and solve the outstanding aspects of the present problems in nursing education.

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1. Ministry of Public Health of Colombia, Columbian Association of Medicine Faculties. *Study of Human Resources for Health and Medical Education in Colombia.* Bogota D.E. 1967, pp. 17-22.
2. Paez de Reyes, Fanny. Sister Aracelly, *et al. Planning for the Future of Nursing Education.* Medellín, 1967, p.4.
3. Ministry of Public Health of Colombia, *op. cit.* p.14.



Photographing an operative field is probably the most challenging task that the medical photographer encounters. This is a job for the expert. It involves both knowledge of surgical asepsis and mastery of photographic techniques. Ninety percent of medical photography is in color. In this picture, the author is using a 35 mm. camera with a 105 mm. lens.

Medical photography — a century of progress

Camera at the alert, the medical photographer has joined the ranks of those who make up the health team. He has won his spurs as a participating and contributing member of hospital personnel.

Jacques Doyon

One hundred years have gone by since the first hospital department of medical photography was launched in France by two doctors, Hardy and de Montmeja, members of the staff of Saint Louis Hospital in Paris. This was in 1869. The value of photography in the medical field seems to have been almost immediately recognized. Actually, its success had been predicted almost 30 years earlier by another physician, Dr. A. Donne, who had himself succeeded in producing microscopic slides. Today, thousands of highly specialized photographers are at work in hospitals the world over. Medical photography has become a recognized and respected discipline, exciting the interest of many young persons who will be the leaders of the future in this area.

Doctors are particularly aware of the role of photography in medical education. For many years, medical students have benefited from the countless numbers of photographs used to illustrate their textbooks. Many a lecture has been brightened and clarified through the use of slides. Audio-visual aids have become indispensable means of communication. The student absorbs ideas more readily and has a greater depth of understanding because he is able to see the total picture.

Preparation of visual aids

Faced with a persistent need for visual aids, doctors have turned to those who can offer professional help in this field. Artists and photographers assume the responsibility for the creation of all materials required for projection, and consequently have become essential members of hospital personnel. Working together, the medical artist and medical photographer form a highly specialized team, producing thousands of items each year.

There are still many people who question the need for the hospital photographer. In the department that I direct, 15,000 photographs and slides are processed annually, as well as numerous 16 mm. films, both silent and with sound.

Mr. Doyon is the Director of the Department of Medical Photography, Hôpital Sainte-Justine, Montreal. He is a member of the Association des photographes professionnels, and of the Photographes médicaux de la province de Québec.

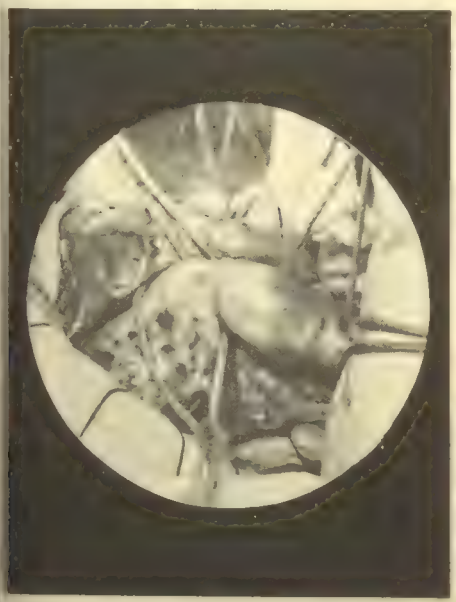
All of this is necessary because of the importance of maintaining permanent photographic records for use in scientific research, medical practice, and teaching.

Obviously, the job must be in the hands of qualified personnel. The photographer works under the guidance of the physician, and is concerned with any aspect of hospital activity that has photographic significance.

The medical photographer

Those who enter the profession must be expert practitioners of photography generally and, in addition, must possess special attributes that will gain their acceptance as photographic experts in medical work. The medical photographer's success depends on the confidence he is able to inspire in his colleagues, and his reputation as a skilled worker.

The prospective candidate must complete secondary school, acquire a diploma in photography, and engage in additional study in human anatomy and physiology.



Coarctation of the aorta prior to surgery. In the operating room the photographer's choice of subject material must be appropriate to the surgical specialty and must meet the surgeon's approval. Speed is essential, and usually there is no going back for a second attempt.

He is required to serve an apprenticeship in a hospital under the supervision of a qualified medical photographer.

Continuous study is a necessity since he must keep abreast of new developments in the field of photography and in medical science. He must have a sensitive professional conscience, exhibited in the scrupulous care and precision with which each item is prepared. His ability to select photographic material wisely, his integrity, and his initiative are effective factors in winning the confidence of others. In photographing patients, he must be able to display sympathy, tactfulness, and devotion to duty. He must be knowledgeable about the hygienic measures required in the prevention of disease transmission, since his duties carry him to the autopsy room the operating room, and many other hospital areas.

In addition to scientific knowledge, the medical photographer must have exceptional powers of observation and considerable dexterity in the use of the camera, particularly when taking photographs of an operation.

He must maintain an interest in medical matters generally, although he will never be called upon to care for patients nor to take scalpel in hand. His daily routine brings him into contact with medical personnel at all levels, as an active participant in hospital life.

In the province of Quebec alone there are, at the moment, some 50 medical photographers. They share in common a high degree of expertise in technique. These photographers are able to make a contribution when they sense that it is their special skills, experience, and ability that are needed to place important records in the hands of the physician; otherwise they drop to the level of simple technicians who press a button, develop film, and mount slides. The medical photographer must believe that his work is the answer to a real need – that through it a doctor is enabled to visualize a lesion more precisely, and teach others about it more effectively.

Scientific value

Photography is especially helpful in following the course of an illness. We can watch the patient's progress or his deterioration. For example, in orthopedic surgery a good photograph can effectively demonstrate the results of surgical intervention. Also, patients with rare diseases can be photographed; their pictures become permanent records of the particular syndrome or lesion.

From a legal point of view, photography offers protection both to the doctor and to the hospital, since the courts accept pictures that originate from an official source, such as the hospital's photographic department.

Types of medical photographs

The medical photographer's subject material is varied. In addition to actual patients and disease conditions in general, he photographs anatomical specimens, cultures, chemical reactions, medical documents of all types, drawings, graphs, electrical tracings, such as one finds in EEG and ECG, electrophoresis and immunoelectrophoresis.

In conclusion I extend my thanks and gratitude to all nurses who have assisted us, particularly when we have had to work in the operating room or in the patient's room. Their help and their cooperation have enabled us to produce better pictures in the interest of both patients and doctors. □

Medical illustration — an art and a science

Medical illustration has become an indispensable feature of scientific life. Through it, the printed or written word takes on life and meaning; the obscure becomes clear; the incomprehensible gains meaning.

Madeleine Gagnon

Medical illustration – what is it, art or science? Probably it is both – an art, because skill in drawing is a prerequisite; a science, since the artist must complement his artistic ability with a body of scientific theory.

There are two distinct types of medical illustration: medical art and medical photography. In this article we are concerned with the former, although the one profession complements the other, and maintenance of cooperation between the two is essential.

History

Through the ages, man has continued to record his progress through his art. Bits of sculpture, paintings of humans, of animals or of geometric forms adorned the walls of the caves that housed primitive peoples. Each civilization, in turn, has contributed to a growing body of artistic knowledge that has presently reached impressive proportions.

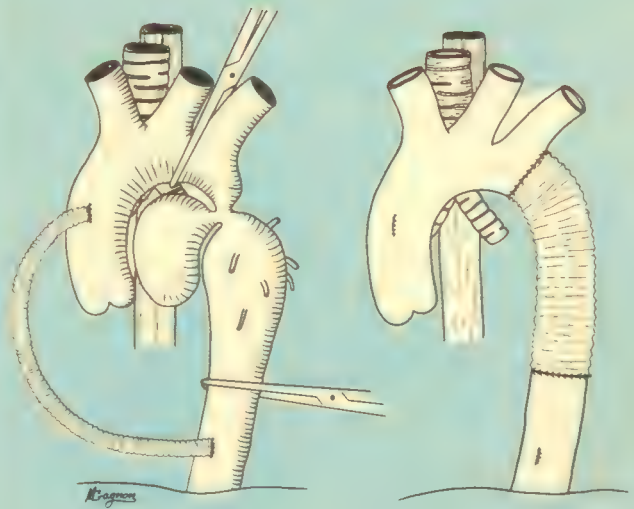
Around the end of the fourth century, artists were exhibiting an amazing degree of skill both in painting and in sculpting either the whole human form or parts of it. At the same time, the developing professions of medicine and surgery began to use illustrative material to provide greater depth of knowledge about human anatomy. These illustrations, while fairly well executed, were based on the results of animal dissection and the artist's powers of imagination.

Leonardo da Vinci, working in the fifteenth century, was one of the first to produce highly successful anatomical art. Della Torro, von Calcar, and Andreas Vesalius followed. The latter has been called "the father of medical illustration." His knowledge of art and of anatomy made his contribution particularly outstanding. The publication of his *De humani corporis fabrica* in 1543 marked the beginning of scientific medical art.

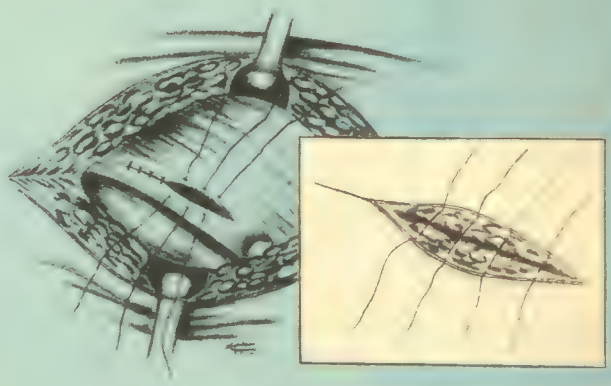
Between the sixteenth and nineteenth centuries, medical illustrations dealt mainly with physical anomaly or deformity and were of fairly good quality. Although there was no attempt to concentrate specifically on medical topics, these particular works had both artistic and scientific value and were carefully preserved.

On the North American continent, medical art was introduced by Herman Faber in 1853. In 1894, Max Broedel immigrated from Germany to the United States. He settled in Baltimore and, in 1911, founded the first school of medical illustration at Johns Hopkins University School of Medicine. He trained medical artists of great promise who subsequently carried on his work. At the present time

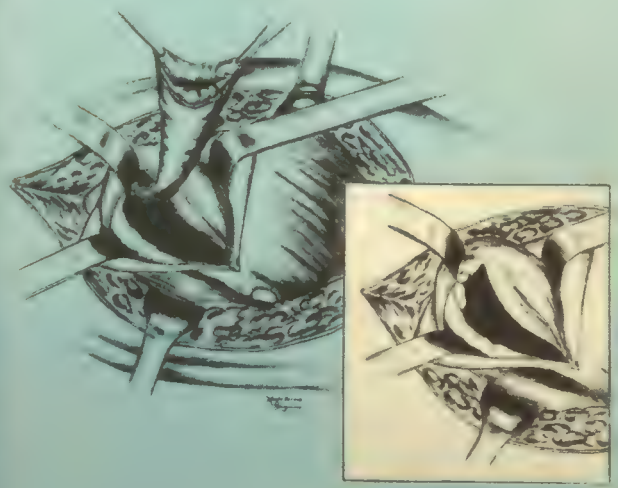
Miss Gagnon, a graduate of Hôpital Sainte-Justine, Montreal, and a former operating room nurse, obtained her certificate as a medical illustrator in 1956 from the Association of Medical Illustrators.



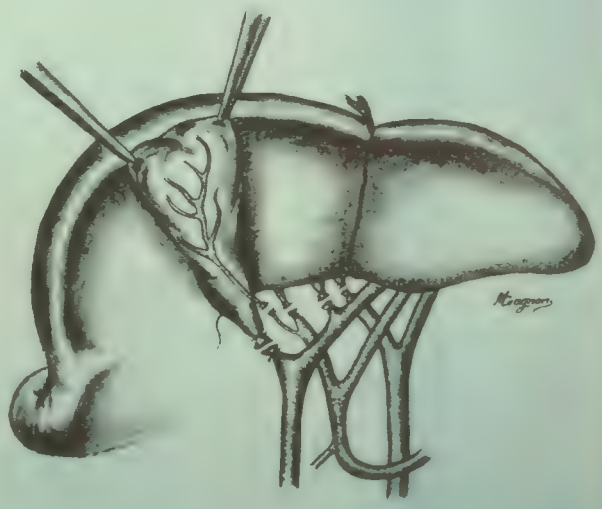
Resection of an aortic aneurysm in a child.



Inguinal hernia repair – closure of the incision.



Inguinal hernia repair – resection of the hernial sac.



Primary cancer of the liver in a child. Dissection of the hepatic pedicle. Cutting and tying of the cystic duct, cystic artery, the right hepatic artery, the right branch of the portal vein, and the right hepatic duct.

there are several schools of medical illustration in the United States, one in London, England, and one in Toronto. It is hoped that another such school may open in the near future in the province of Quebec.

Value of medical art

Medical art has become a connecting link between medical teaching and practice. Through its use, theoretical principles are made more comprehensible both to medical and nursing students. The design and preparation of scientific exhibits, television productions, and movie films all fall within its range of interest. Literary works of various types – books, journals, pamphlets – benefit from the skill of the medical artist, as do the advertising materials of pharmaceutical and other manufacturing firms. Last, but not least, medical art has even found a place on the walls of institutions in the form of murals.

The medical artist

The field is open to both women and men, but the percentage of male artists is presently higher, probably due to a steady increase in salary over the past few years. This is especially true of the United States.

The prospective student should be a high school graduate with additional preparation in the fine arts, including study of the human body – nude and clothed; artistic composition; sketching; color theory; design; and history of art. Among other personal attributes, he must possess exceptional powers of observation and be capable of intense concentration. Finally, he must have general knowledge pertaining to medical science.

The medical artist receives his training in a school specializing in this field. The course extends over a period of three years and the curriculum includes study of embryology, histology, anatomy and pathology. These lectures are taken with first- and second-year medical students, and the same sets of examinations must be passed.

Attendance at autopsies and surgical operations is a necessity, and the student must become generally familiar with hospital routine. He is expected to complete black and white, as well as colored, drawings of various anatomical and pathological specimens, surgical procedures, and clinical subjects from the different medical specialties.

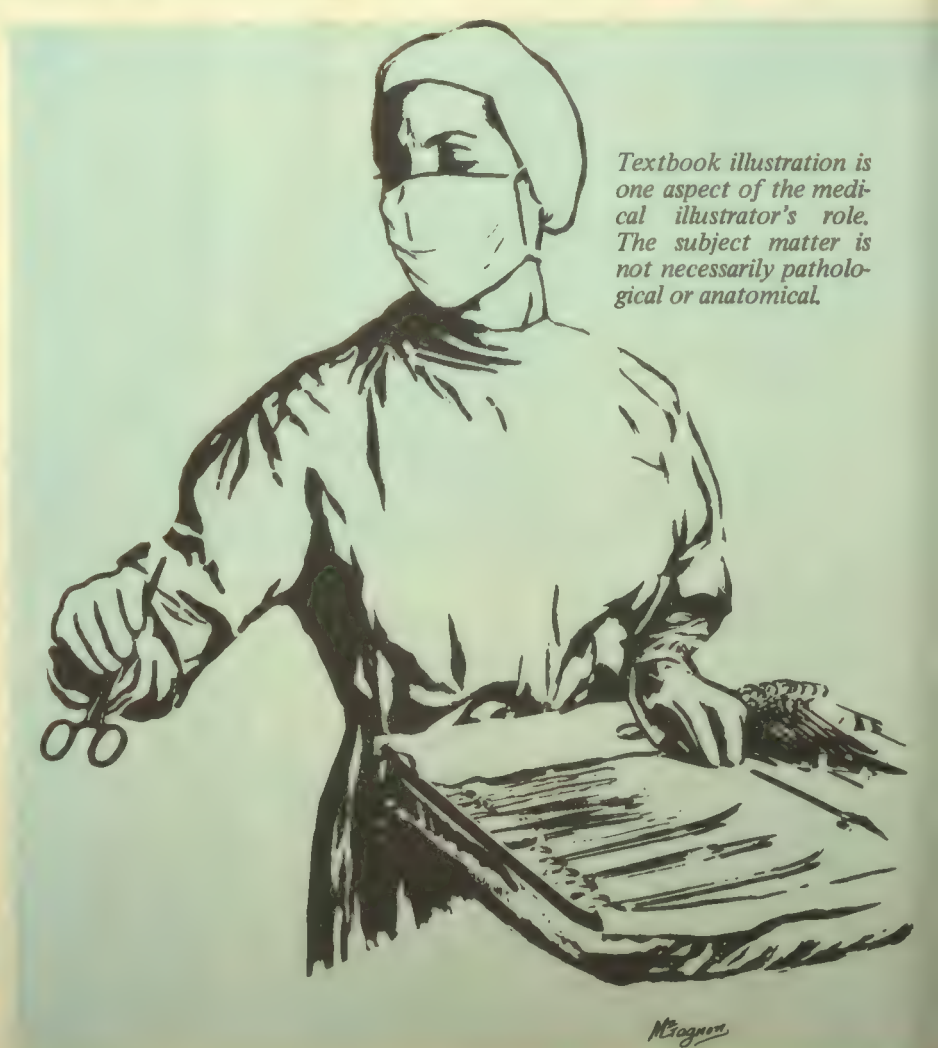
He learns how to design and set up scientific exhibits and how to illustrate books. He studies the history of medicine and is introduced to the basic principles of photography as related to the use of medical art in the production of audio-visual aids of all types.

His goal is the ability to produce illustrations that are clear, exact, stripped of unnecessary detail, and which, at one and the same time, possess scientific value and exhibit artistic ability. The artist does not copy, he creates through his own personal and original efforts. Part of his success will depend on his diligence in keeping up-to-date with new discoveries in medicine and in art.

Future prospects

Since most medical artists are without predecessors in their present jobs, there will be a continuing need for their services in universities, hospitals, research centers, and pharmaceutical firms. Generally speaking, there is a shortage in numbers, with the result that some institutions have found it necessary to employ artists who lack specialized preparation.

The work of the medical artist is well-known throughout the medical world and its value is undeniable in the scientific community. □



Textbook illustration is one aspect of the medical illustrator's role. The subject matter is not necessarily pathological or anatomical.

Nurses are not neurotic

The author wonders, however, how many imaginary diseases the nurse suffers during her career.

Anthea Cohen

The public, as a general rule, are under the impression that nurses are not afraid of catching infections from the patients they nurse or of contracting similar diseases. How wrong they are!

On the medical ward, for example, the nurse assiduously reads all the notes so that she knows all about the patient she is nursing, and, bingo! she has got the lot.

"I've got an awful pain in my chest," she says, darkly, to one of her companion nurses, while they are engaged in the inevitable task of testing the urines. "Do you think I'm going to have a coronary? "

Or she surreptitiously tests a specimen of her own urine in order to see whether she's got diabetes, kidney trouble, or whether anything has happened to her liver function. With trembling fingers she drops a Clinitest tablet into her specimen and, joy of joy, it remains blue. Then, she gets shifted to a surgical ward.

Promptly, she gets a pain in the right side of her tum and thinks: "Here it is. It's my appendix."

But she waits a couple of hours and the pain disappears, only to be replaced by one in the region of the gall bladder. She is caught by the sister examining the whites of her eyes tentatively in a hand mirror, trying to see if she has become jaundiced.

"You should not wear mascara on duty, Nurse" says sister crisply, and our neurotic one shambles off, wondering how many times during a training you can be misunderstood.

Everything except nappy rash

In the children's ward she is afflicted with imaginary worms, German measles, enlarged tonsils, pyloric stenosis and, in fact, everything with the exception of nappy rash, and when she leaves the children's ward she gives a sigh of relief to think she didn't catch anything from the little darlings, but this time she gets clonked on the orthopedic ward.

Here, she contracts in rapid succession, osteo-arthritis of hip, a slipped disc, cartilage trouble in both knees, wry neck and a tendency to fallen arches.

Get a case of measles in the middle of the ward, and all the nurses will become very bright about how they "couldn't care less," but you watch 'em when they are passing the bed before the patient is moved out of the ward! They're all holding their breath in case the measley germ takes a quick, jet-propelled dive and goes up their nose in passing. Oh, they'll nurse him faithfully enough, but not without being sure that they have got measles too, because they get a sore throat, or think they see a rash on themselves.



Holding their breath as they pass the measley patient . . .

The experienced and older ward sister, of course, has the roughest time, because she knows it all and has had, in her imagination, every kind of dreaded "lurgy" known to the doctors and some that aren't. If she has a headache she thinks she's suffering from: a brain tumor; that she's going to have a stroke; or she's got typhoid coming on.

After all, she knows the symptoms. If she gets a pain in her chest, it's never just indigestion, it's: a coronary; an aortic aneurism; or a hiatus hernia.

A quick stab of pain on one side of her face and she's got Trigeminal neuralgia coming on, or osteomyelitis of the jaw; nothing, in any circumstances, that is simple.

Of course, these neuroses aren't attached only to herself but they can be superimposed on her mother, her father, her sister, her brother or her husband. They usually have a great deal more sense and say something like:

"Oh, get off, I've only got the stomach-ache" and leave her to her dark mumblings of "diverticulitis" or "duodenal ileus" and all those gay little prognosticisms.

However, among all this sea of diseases there is one comforting thought which will take the average nurse successfully through her training and help her to cope. No matter how many diseases she meets she can't die of them all! □

Reprinted from *Nursing Mirror and Midwives Journal*, February 7, 1969 issue, with the kind permission of the editor and the author.



1. Rooming-in is a plan whereby mother and infant share the same room and are cared for together. It permits the mother to begin to care for her baby during the early days of life under supervision of a nurse. The father, when he visits, also participates in the care of his newborn.



2. At St. Michael's Hospital, Toronto, a young couple may arrange with their obstetrician during the prenatal period for the young woman to be admitted to a unit that allows rooming-in. Starting the first day after delivery if the mother is ready, a special baby-care cart is taken to the mother's room during the day; at night it is returned to a special unit nursery so the mother will get adequate rest.



3. As soon as the mother feels able, she begins to care for her infant—with supervision and health teaching. Those who benefit most from rooming-in are those with their first baby. It helps provide a sense of confidence in their ability to care for the babe and to ease anxiety and fear before having to cope alone at home.

Rooming-in is not a new idea. Many Canadian hospitals have adopted this kind of family-centered care for parents who want it. The student who provided this photo-article recognizes one important point, however: nurses must be convinced of the value and be willing to participate in parent-care as well as baby-care, if rooming-in is to work.

Rooming-in

brings family together

Barbara Coome

Miss Coome is a third-year nursing student at St. Michael's Hospital School of Nursing in Toronto.



5. The father participates in the care of his baby early, rather than just seeing him through glass. The parents can learn, together, the essentials of baby care. Specialists believe this may lead to a closer and more natural family relationship.



4. The mother has the satisfaction of being able to observe her baby during the day, and to learn how he reacts. She can also practice her care under supervision and ask questions about things that trouble her. The baby can have his needs met as soon as they are expressed—and babies don't understand delay.



6. The nurse on a rooming-in unit must be proficient in both postpartum care and nursery care. It is much more demanding for the nurse than on conventional units. She must be able to support and guide the new parents, and her skills must include a sound understanding of human relations. Often the success or failure of the rooming-in concept depends on the nurses' attitudes.

research abstracts

Crotin, Gloria G. *Nursing supervisors' perception of their functions and activities.* Pittsburgh, 1968. Thesis (M.N.Ed.) University of Pittsburgh.

This study was conducted in six general, short-term care hospitals varying in size from 301-600 beds. Four hospitals were defined as community hospitals and the remaining two as university-centered. Eighteen day nursing supervisors acted as the sample participants.

A structured, fixed-alternative questionnaire was the tool selected for this descriptive study. The method employed in the construction of the questionnaire was designed following the collection of job descriptions from the study hospitals for the day nursing supervisors. Four major categories were established for sorting the functions: (a) Administrative tasks of a non-nursing nature, such as planning staff hours, vacation time, absenteeism, obtaining equipment and supplies; and administrative tasks of a nursing nature, such as the development of nursing care procedures, job descriptions, review of nursing research. (b) Coordination of services, patient-care and personnel. (c) Evaluation of patient-care and personnel. (d) Teaching and development of self, staff, and patients. From these categories, new reconstructed statements of functions were prepared consisting of 37 functions.

The findings indicated the following: 1. The nursing supervisors in the sample had limited education following graduation from a diploma nursing program. Only 38.9 percent of the sample had baccalaureate preparation. 2. More than 80.0 percent of the supervisors' responses indicated they performed the functions listed in the questionnaire. 3. All respondents stated that they performed the following two functions and they also agreed that supervisors should perform these tasks. The tasks pertained to determining the adequacy of nursing personnel, qualitatively and quantitatively, on specific patient units, and participating in the evaluation of professional and non-professional nursing personnel. 4. In the category of coordination of services, patient-care and personnel, as well as in the category of teaching and development of self, staff, and patients, there was not one function about which total agreement was reached by the subjects. 5. The supervisors registered their greatest opposition to tasks in the category of administration. These were the tasks of acquiring special equipment, supplies, and drugs for a patient unit and approving requisitions for new materials and equipment. 6. All functions in the teaching and development category received two or more negative responses from the supervisors, indicating that they did not wish to carry out the described functions, except for the function of providing individual instruction to nursing personnel. 7. The university hospital supervisors indicated that they performed more of the functions listed in the questionnaire than their counterparts in the community hospitals. 8. The study revealed contrasting views between the two groups of supervisors. Supervisors in the community hospitals showed a greater willingness to perform the stated functions than did the university-centered supervisors. However, among the functions checked not performed, the university-center supervisors expressed a higher level of agreement that they should be performing the stated functions, than did those employed in community hospitals.

The major conclusion indicated that there seems to be a confusion of roles or lack of clarity in the job descriptions of supervisors and other nursing personnel. Responsibility for teaching staff members appeared to be a neglected function unless it was done on an individual basis. Group confrontation may be threatening to a nursing supervisor who does not possess the skills required for group leadership in conducting patient-centered conferences.

Proulx, Yolande. *A study to determine the influence of selected factors in choosing a head nurse's position.* Boston, 1968. Thesis (M.S.) Boston Univ.

This study was undertaken to identify some selected critical factors that would deter or attract nurses to head nursing.

The data were gathered by means of questionnaires administered to a total group of 45 participants working in one hospital and enrolled in one university school of nursing, both located in a southeastern city of Canada. The participants consisted of 11 prospective clinical teachers and 21 potential head nurses who were currently enrolled in a post-basic program, and of 4 head nurses and 9 clinical teachers who were presently employed in one hospital.

The data were tabulated and analyzed to identify the participants' work background, personal attributes, forces that attracted nurses to head nursing, factors that would deter clinical teachers from head nursing, and outside motivational factors that influenced their occupational choice.

On the basis of the findings of this study, the following conclusions were drawn in relation to the participants from one university and one hospital located in a selected city of southeastern Canada. 1. The clinical teachers graduated more recently from a diploma program than did the head nurses. 2. There were more head nurses functioning without educational preparation in their field than there were clinical teachers without formal preparation. 3. Personal qualities and abilities required of the prospective head nurse were the same as those desired for the potential clinic teacher. 4. Communication skills and knowledge in the assigned clinical area were qualities that were perceived as vital to success for both head nurses and clinical teachers. 5. Working opportunities were the most influential factors in attracting nurses to head nursing. 6. The bureaucratic aspects of head nursing were indicated as forceful factors in deterring clinical teachers from head nursing. 7. Directors of schools of nursing have been more active in recruiting educationally qualified clinical teachers than their colleagues in nursing service administration have been in recruiting formally prepared head nurses. 8. Teachers have been attracted to teaching by the example of a competent faculty member; head nurses were influenced in their choice by a situation whereby they were made aware of the need for educationally qualified head nurses as a condition to the improvement of nursing care. 9. Advertisements in professional magazines were the least influential source of recruitment for both groups of clinical teachers and head nurses.

In view of the findings, it was recommended that three separate studies be undertaken, utilizing more refined or standardized tools to: 1. determine the personality traits that are most conducive to success in head nursing; and 2. determine if there is a correlation between the head nurses' perception of the working conditions and the actual working situation. □

books

Infectious Diseases by Carl C. Dauer, Robert F. Korns, and Leonard M. Schuman. 262 pages. Cambridge, Mass., Harvard University Press, 1968. Canadian Agent: W.B. Saunders Ltd., Toronto.
Reviewed by Dorothy M. Mumby, Director, Public Health Nursing, City of London, Board of Health, London, Ont.

This book is a record of a series of vital and health statistics monographs sponsored by the American Public Health Association. It is a sequel to a similar one on *Accidents and Homocide.*

This volume is divided into three sections: infectious and parasitic diseases; other specified infectious diseases; and respiratory diseases.

Statistics presented for the years 1949 to 1961 compare morbidity and mortality rates by age, sex, color, and geographical division of the lunited States. The reasons given for limitations of the morbidity and mortality data are inadequate reporting and inaccuracy of diagnosis.

A short history and factors relating to an increase or decrease of a disease are discussed as each disease or group of diseases is presented. Diseases with a high incidence rate and death rates are presented, as well as those seen infrequently in the US.

The tables and figures are well presented. A 40-page appendix of incidence, incidence rate, and numbers of deaths by geographic division and states is a handy reference. References and a detailed index are also included.

This book would be valuable as a reference for statistical data on infectious diseases in the United States. It does not give up-to-date information of the infectious disease picture in 1969. It is understandable but unfortunate that this type of data cannot be collected and presented within a shorter time.

The Ophthalmic Assistant by Harold A. Stein and Bernard J. Slatt. 406 pages. Saint Louis, Mosby, 1968.
Reviewed by Dr. S.Y. Shirley, Ottawa.

Demand for highly skilled ophthalmic assistance has led to a new paramedical technician, the "ophthalmic assistant." These assistants have joined the growing ranks of paramedical personnel, which include x-ray technologists, laboratory technologists, inhalation therapists, etc.

This book was written for the ophthalmic assistant who assists the ophthalmologist in the day-to-day care of eye patients. The role of the ophthalmic assistant is to provide reliable and competent eye care prior to and following regular visits to offices and clinics.

The text is well illustrated and covers the technical aspects of ophthalmology, ocular instrumentation, diagnostic methods, procedures regarding sterility, and supervision of ocular instruments. It describes the common ocular diseases and the nature of emergency eye patients. One chapter deals in simple, easily understood terms with the common refractive disorders and optics of the lens required for correction. Another section deals with community ocular problems, with a chapter on eye screening programs, which would be of particular interest to the industrial and school nurse.

This book is of tremendous value to the nurse working in an eye clinic or an ophthalmologist's office. It covers the practical field of eye diseases better than any nursing textbook I have seen on this ubject. For this reason, I would recommend it to nursing schools as a text and certainly it should be in all nursing school libraries.

Handbook of Diseases of the Skin, 9th ed., by H.O. Mackey. 424 pages. New York, St. Martins Press, 1968. Canadian agent: Macmillan Co. of Canada, Ltd. Toronto.
Reviewed by Dr. Robert Jackson, Ottawa.

This book is reported to be for "students as a practical guide to the clinical study and treatment of the diseases of the skin." Actually it is an out-of-date (by at least 30 years) abbreviated encyclopedic textbook of dermatology with a few dibs and dabs of modern cutaneous medicine.

The first part on anatomy and physiology is too brief to be of any value. The stratum lucidum has been known not to exist for at least 15 years, yet it is still described.

In discussing methods of examination, no mention is made of the use of a hand lens, nor is mention made that the hair and nails must be examined, as should the lymph nodes.

The chapters on treatment read like Alice in Wonderland. It is recommended that diseases for which there is now specific treatment should still be treated by arsenic, e.g., syphilis, pemphigus and pellagra. To use "ichthyolated yellow paste" for impetigenized eczema would almost amount to malpractice. No mention is made of the not uncommon neomycin contact dermatitis or to the yellow pigmentation of the teeth following the administration of tetracycline to pre-pubertal children.

At least 150 diseases are described by very short, inadequate descriptions. Some of the common skin conditions that the student should learn are dealt with in a cursory manner (e.g. contact dermatitis 1/2 page, acne vulgaris 2-1/2 pages, stasis dermatitis 1-3/4 pages).

Almost all the photographs are out of focus, are far too dark to show anything, or show rare diseases that the average busy practicing dermatologist might see once a year (e.g., there are three poor chemical photographs and six poor photomicrographs of sarcoidosis). The value of these to the student is nil. There are no color photographs, and no references.

There are numerous proofreading errors, e.g., p.44, lupus erythematosis (for erythematosus), and p.28, "it is unusual for patients who present with allergies due to food not to have a family history of atrophy" (for atopy).

There are excellent, practical, up-to-date, short textbooks on dermatology with excellent black and white and color photographs (e.g., Stewart, Danto, and Maddin, *Synopsis of Dermatology,* 1966). It is difficult to know to whom this book will prove useful. It is certainly not recommended for nurses.

The CNA library urgently requires the following issues of the *Journal of Nursing Education,* published by the Blackston Division of McGraw-Hill.

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Microbiology and Pathology, 9th ed., by Alice L. Smith. 723 pages. Saint Louis, Mosby, 1968.
Reviewed by Heather Blair, Instructor, School of Nursing, Ottawa Civic Hospital, Ottawa, Ont.

This textbook would be a valuable addition to the library of any nursing school. The author provides a comprehensive study of microbiology and an outline of the principles of pathology, including 11 chapters on the pathology of the major body systems.

The assets of this book include the well-chosen illustrations that give added meaning to the text, and the convenient summary charts that give easy access to important facts. The questions at the end of each chapter serve as a guide to important concepts.

In Part I, chapter two, dealing with "The Cell," and chapter three, "The Bacterial Cell," are too detailed in places for the use of nursing students. For example, although it is valuable for the student to know the basic shapes and names of bacteria, it is unnecessary to demand that she should have a knowledge of the structure of the bacterial cell.

Excellent chapters within Part I include chapter 14 on antibiotics and chapter nine dealing with specimen collection. In both chapters the clinical relevance of microbiology is clearly evident. The chapter on viruses is up-to-date and provides complete coverage of an area of microbiology that seems to arouse the curiosity of nursing students. The existence of both non-pathogenic and pathogenic microorganisms is made evident by the chapter on "The Microbes Daily Contribution." I feel it is important that the student be aware of this balance. Again, clinical references are made; for example, the roles of the normal flora of the bowel in vitamin K synthesis.

Chapter 34 on recommended immunizations is a useful and important reference for health-teaching purposes. The weight given to preventative measures in Part I of this textbook is admirable. Unit five, "Microbes, Pathogens and Parasites," is thoroughly, yet simply, explained. I would recommend it as a reference for intermediate students studying communicable diseases.

Part II of the text, which deals with pathology, describes clearly and concisely the major disease processes of the body systems. It is useful as a reference for senior students. I would not recommend this section of the book for junior or beginning intermediate students, however, since pathology and nursing care are not correlated. A senior student should not have difficulty making this connection.

Disease in Infancy and Childhood, 6th ed. by Richard W.B. Ellis and Ross G. Mitchell. 687 pages. Edinburgh and London, E. & S. Livingstone Ltd., 1968. Canadian agent: Macmillan Co. of Canada Ltd., Toronto.
Reviewed by Dr. Helen Evans Reid, Dept. of Medical Publications, The Hospital for Sick Children, Toronto, Ont.

This comprehensive, well organized book provides senior medical students with an introduction to the study of the diseases of infancy and childhood.

The text is not concerned with specific therapy. It presents, with well-illustrated examples, conditions the doctor will encounter in various systems, such as the disorders of metabolism and storage, disorders of the blood, and disorders of growth and development. Prognosis and treatment are only briefly mentioned.

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called upon to treat them, should find this book invaluable. It is no surprise that this text is already in its sixth edition.

The Psychoanalytic Approach, edited by John D. Sutherland. 77 pages. London, Baillière, Tindall & Cassell Ltd., 1968. Canadian agent: Macmillan Co. of Canada Ltd., Toronto.
Reviewed by Dorothy M. Pringle, Lecturer in Nursing, McMaster University School of Nursing, Hamilton, Ont.

This small book comprises five lectures sponsored in 1967 by the British Psychoanalytic Society. The purpose of the lectures was to help those people interested in psychoanalysis become more aware of how the analyst works and how his knowledge and research can provide insight into human behavior. On a small scale the book accomplishes this aim.

The five papers recorded are different in content and value. Robert Gosling's discussion of transference is excellent. He uses case material to illustrate this complex concept and discusses the relationship between patient and analyst in terms of everyday experience. Elliott Jacques' treatment of guilt, conscience, and social behavior is equally enlightening. He traces the child's development of these characteristics through positive and negative learning experiences. Sidney Crown's paper on psychoanalysis and science is concise and well-presented. He defends the psychoanalytic position of not distorting a patient's analysis in order to obtain data, but he presents alternate ways of conducting psychoanalytic research.

Two other papers included in the collection do not meet the objective of the series as well as do the others. Martin James' "Psychoanalysis and Childhood 1967," is a rambling affair that attempts to cover a wide spectrum of topics but leaves the reader to wonder about childhood in 1967. Elizabeth Botts' "Psychoanalysis and Ceremony" is, in fact, a detailed anthropologic study of the Kava ceremony of the Kingdom of Tonga. The writer claims her objective is not to show how a knowledge of unconscious mental processes helps in the understanding of social behavior, but only to understand this particular ceremony. The objective of the series of articles would have been better reached if Dr. Botts had made the understanding of social behavior, as illustrated by this ceremony, her main objective, and had then explicitly referred to this objective throughout her paper.

This book would make interesting reading for those nurses concerned with broadening their understanding of the application of psychoanalysis. Graduate students in psychiatric nursing would find it helpful in understanding present-day analytic thought. Its usefulness for undergraduate teaching, however, is questionable.

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2. *Basic documents. Nineteenth edition.* World Health Organization, Geneva, 1968. 196p.

3. *Behavioral science, social practice, and the nursing profession* by Powhatan J. Wooldridge and James K. Skipper and Robert C. Leonard. Cleveland, Press of Case Western Reserve University, 1968. 108p.

4. *Canadian Medical Directory.* Compiled from the daily medical service bulletins, Toronto, 1969. 704p. R

5. *Developing behavioral concepts in nursing* by Loretta Zderad and Helen C. Belcher. Atlanta, Southern Regional Education Board, 1968. 121p.

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9. *Media Canada: guidelines for educators* edited by J.D. Miller. Toronto, Pergamon, 1969. 59p.

10. *A multiple assignment model for staffing nursing units* by Harvey Wolfe. Baltimore, 1964. Ann Arbor, Michigan, University Microfilms, 1969. 306p. (Theses—Johns Hopkins.)

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13. *La recherche au Canada français* par Louis Baudouin. Montréal, Les Presses de l'Université de Montréal, 1968. 164p.

14. *Preparation for retirement booklets.* Ann Arbor, Michigan, University of Michigan,

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15. *A study of three concepts in team nursing* by Sister Mary Barbara Anderson. Berkeley, 1967. Ann Arbor, Michigan, University Microfilms, 1969. 18p.

16. *Report of First Nursing Research Conference, April 5-7, 1965, New York.* New York, American Nurses' Association, 1965. 153p.

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18. *Report of Third Nursing Research Conference, February 27-28, March 1, 1967, Seattle Washington.* New York, American Nurses' Association, 1967. 301p.

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20. *Vocabulary of medicine and related sciences; English, French and French-English* by W.J. Gladstone. New York, 1968. 169p. R

21. *Vocational choice and satisfactions of licensed practical nurses; excerpts from a thesis submitted at the University of Minnesota in partial fulfillment of the requirements for the degree of Doctor of Philosophy* by Eleanor Mae Walters Treece. New York, National League for Nursing, 1969. 61p. (League exchange no. 87.)

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22. *Brief to the Commission of Enquiry on Health and Welfare of the Government of Quebec.* Montreal, P.Q., Association of Nurses of the Province of Quebec, 1969. 1v.

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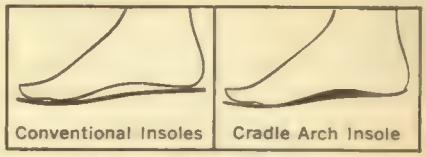
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30. *Submission to the Special Committee on Science Policy.* Ottawa, Canadian Nurses' Association, 1969. 18 + 3p.



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AUDIO VISUAL MATERIAL

45. *Uniforms of Royal Columbian Hospital, School of Nursing, 1901-1967.* New Westminster, B.C., 1967. 10 color slides, 35mm.

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46. *L'avènement de l'infirmière clinicienne – spécialiste.* Montréal, Université de Montréal, Institut Marguerite d'Youville, 1967. 17p. R

47. *Comment l'évaluation est-elle perçue par l'infirmière dans un hôpital régional?* Montréal, Université de Montréal, Institut Marguerite d'Youville, 1967. 13p. R

48. *A comparison of the perceptions of public health nurses and their alcoholic patients regarding the priority ranking of nursing needs* by Marguerite Catherine Williams. Toronto, 1968. 59p. R

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The Canadian Nurse

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In this column in August 1967, we suggested that the Canadian Nurses' Association's methods of petitioning the federal government and of informing government personnel of the association's activities, objectives, and policies were less than satisfactory. We suggested that the federal government's increasing involvement in affairs that directly or indirectly affect nurses, nursing, and the health of the people of this country demanded a more formal type of lobbying than presently being used by CNA.

At that time we had scant information on which to base our opinion: we had not conferred with other associations about their efforts to lobby government; we had not interviewed any members of parliament to get their opinions on the value of lobbyists and lobbying; and we had read little about lobbying in Canada, mainly because of the dearth of material on the subject.

Now, we have done our homework: we have compared notes with professional associations that employ lobbyists (in Canada, associations with lobbyists on staff are reluctant to label them lobbyist, even in private conversation, and refer to them as "public relations officers," "information officers," or some other innocuous title); we have interviewed two members of parliament and have spoken to several others informally; and we have read as much as we could find on lobbying in Canada, although it is a subject that has been surprisingly neglected by the news media.

Our conviction that CNA needs a lobbyist on staff has not changed; if anything, it has been strengthened. We believe that a full-time lobbyist would benefit both parties — the association and the government.

V.A.L.

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Letters Welcome

Letters to the editor are welcome. Because of space limitation, writers are asked to restrict their letters to a maximum of 350 words.

Parents — members of the team

During the past year I have been part of a community team active in the field of mental retardation. Although employed by an institution for the mentally retarded, my role has been primarily in the community. I met and learned much from team members active in the community – family physicians, public health nurses, social workers, teachers, psychologists, and clergy. I also talked with the other important team members – the parents of the mentally retarded.

Only a parent of a mentally retarded child can fully understand the feeling of any parent when he first learns his child is retarded: shock, disbelief, anger, rejection, and guilt are all experienced in greater or lesser degrees. Most parents report getting much professional support at this time. As the initial crisis passes with time, the parent and child begin the day-to-day task of living; and as the family becomes more adept, the professional moves into the background. This is as it should be. Care should be taken, however, that the family knows this support is not completely withdrawn, only less active.

Parents also need to be encouraged to use their initiative, as many are afraid that if they are "too good" or "too imaginative" in caring for their child, professional help will disappear. They need to know this is not so.

Parents – good parents – frequently express feelings of guilt because "sometimes we wish we didn't have this child." I think this is normal. Parents of normal children also say there are times when they feel this way. Parents who feel guilty about these feelings toward their retarded child admit to the same feelings, without guilt, toward their normal children. These parents need the opportunity to express their feelings; once out in the open, they fall into proportion.

A legitimate worry of parents rests with the future of their child. They need to know that if anything happens to them, their child will not be alone, that other team members will be able and willing to help. At the same time, they need to be encouraged to make some provisions. Many parents might be surprised to find that the solution to their problem is within their own reach.

I would encourage all workers to take full advantage of contact with parents of the mentally retarded. Everybody can learn. Many times a parent has offered me more than I could offer him. – Lois Patchell, R.N., Smiths Falls, Ontario.

The changing role of the nurse

The article by Helen K. Mussallem, "The Changing Role of the Nurse" (November 1968), has been widely read in Israel. It was required reading and the focal point for group discussion in our baccalaureate program. The article was photostated by the Nursing Department of Kupat Holim (the health insurance division of the federation of labour) and distributed to its key nurses in nursing schools, hospitals, public health agencies, and clinics. At a staff meeting of the Kupat Holim, the directors and supervisors of nursing were so stimulated by the author's approach that they decided to circulate the article among a wider audience.

This article has now been translated into Hebrew. It will be distributed to nurses, doctors, and other key staff in the services. Within the next few months, discussion of the role of the nurse, using this article as a base, will be on the agenda of staff and/or inservice meetings.

I am sure that the article has received equal interest in many countries. We are all acutely aware of the need to redefine our role, and are moving toward this goal in many ways. "The Changing Role of the Nurse," through its clarity and vision, is serving as a stimulus for group thought and action. – Rebecca Bergman, R.N., Ed.D., Acting Head of Department, Faculty of Continuing Medical Education, Nursing Department, Tel-Aviv University, Ramat-Aviv, Tel-Aviv, Israel.

Have you a Christmas

Story Or Message

To Share?

The Canadian Nurse

invites readers to submit original articles about Nursing at Christmas for possible publication in the December 1969 issue.

Manuscripts should be typed double-space on one side of unruled paper, leaving wide margins. The usual rate will be paid for accepted material.

Suggested length: 1000-2500 words.

Deadline date: September 1, 1969.

Send manuscript to: Editor, The Canadian Nurse, 50 The Driveway, Ottawa 4, Ontario.

Names and addresses required

The Payzant Memorial Hospital School of Nursing, Windsor, Nova Scotia, will celebrate its diamond jubilee in the fall of 1969.

In late July or August (the date will be announced later) the Alumnae association will hold a week-end of events, when graduates can get together to celebrate the 60th anniversary.

The alumnae association would like the names (maiden and married) and addresses of graduates with whom they have lost contact. The lending of old uniforms and pictures would also be appreciated.

Please send information to: Mrs. Clarence Boyd, Secretary, Box 3, Windsor N.S. – (Mrs.) Geneva M. Sanford, R.N. Publicity Chairman.

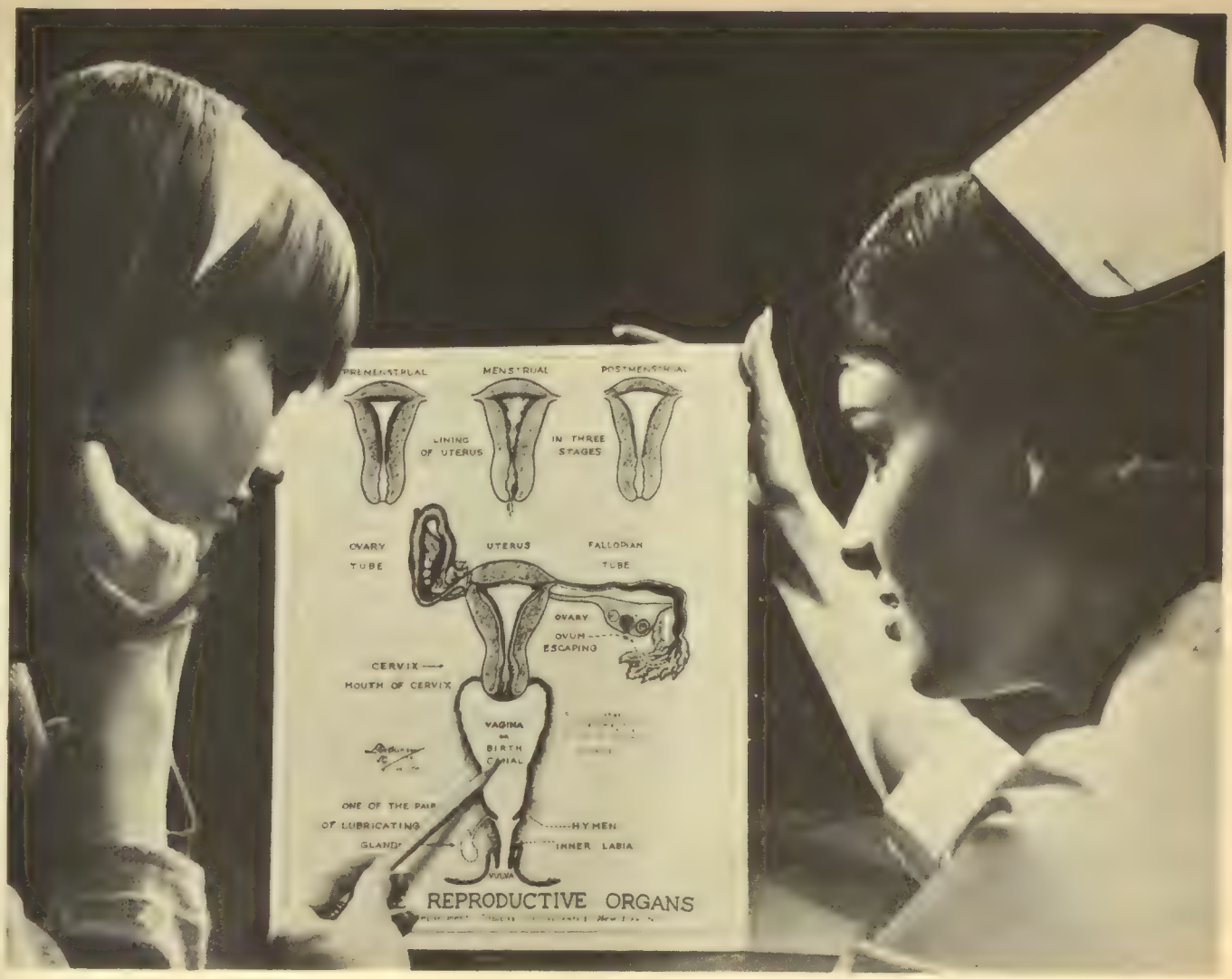
Willing to share knowledge

In her letter to the editor (May 1969) Sister Muriel Gallagher suggests that nurses should start a revolution to get people in our society to look forward to old age. We heartily concur.

In Victoria we started a little revolution of our own by drawing attention to the deteriorating effect, both mentally and physically, that results when only custodial care is given to the aged, and also to the fact that when activity programs are added to meet the psychosocial needs, deterioration is reversed.

One example where this "revolution is carried out is at St. Mary's Prior

(Continued on page



a little knowledge is not enough . . . give teen-agers the facts about menstruation

Some teen-agers have heard they shouldn't bathe or wash their hair during their menstrual periods. Some think unmarried girls shouldn't use tampons. Others say exercise brings on "cramps." No wonder they call it the "curse."

Give them the facts . . . with the help of the illustrations in charts like the one above prepared by R. L. Dickinson, M.D. and available to you free from Canadian Tampax Corporation Ltd. These 8½" x 11" colored charts are laminated in plastic for permanence and are suitable for marking with grease pencil. Social myths can be exploded, too, by giving teen-agers either of the two booklets we will be glad to send you in quantity for distribution. One booklet is written for the young girl just beginning menstruation and the other for the older teen-ager. The booklets tell them what menstruation is, how it will affect them, and how easily they can adjust to it normally and naturally.

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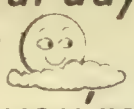
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letters

(Continued from page 4)

Hospital. Here it is common to see a mentally regressed, immobile person become lucid and active.

Recently, the administrator of the Royal Jubilee Hospital presented a bouquet to the nurses at St. Mary's, which appeared in the *Victoria Times:* "We have the highest regard for the Priory concept of extended care and wish it could be developed throughout British Columbia. The work they are doing at the Priory must spread."

Much has been written about our experiences in caring for the aged. We would be pleased to share this knowledge upon request. – Sister Mary Elizabeth, O.S.B., Director of Nursing, St. Mary's Priory Hospital, Victoria, B.C.

Wear uniform with pride

I read with interest Dr. E. Black's comments about nurses, uniforms, and caps (December, 1968). Today I read a reply from four R.N.s (May 1969). For the first time in some 30 years of active nursing, I feel compelled to write to the editor.

Initially, I would like to acknowledge that part of my interest was aroused because Dr. Black is one of those doctors who was never too busy to teach, and a great many nurses learned a great deal from her. I feel a sense of resentment to the tone of the R.N.s' letter.

A uniform has been a part of my life since I first wore the awful probationary style. Then we received our caps, not in a ceremony, but in our classroom and from the hands of our clinical instructor. At that point we were nurses – a proud and happy group.

It is true that a uniform does not make a nurse, nor does a degree make a nurse, teacher, or doctor. One has to have a great deal more than a superficial covering to make her a successful "anything." A uniform, though, does distinguish the nurse who, because she is wearing it on duty, is recognized as a skilled, professionally-equipped individual. It is an indication to a certain important person, namely the patient, that the person in this uniform – and the color really isn't all that important – is his nurse. This is the person who is especially prepared to meet his total needs.

Having recently experienced a lengthy hospitalization, I perhaps have more positive feelings than I might have had otherwise in regard to uniforms. I knew by her cap and uniform when a nurse came into my room. I felt secure with her, and our relationships were on a different level than the other individuals concerned with some phase of caring for patients in hospital. I especially enjoyed the bright young student in her pinks who was usually responsible for waking me each morning. It wasn't a trial to be aroused so cheerfully by a pleasant, well-groomed young lady in an attractive uniform, with her cap and band indicating her experience.

In the muddle of people who are included in the patient's daily routine, it is reassuring to be able to recognize who is what; at times it's difficult, but I feel from a patient's point of view, uniforms and caps are symbols of those who are prepared to give nursing care.

In our profession, as in others, we have faced many changes. We have accepted them well and appreciated the improvements they brought with them. Styles in uniforms are more practical and laundries have made us aware that bibs and aprons are expensive and impractical in this "swinging age." However, can we not wear our uniforms and caps with pride in the setting for which they were designed? Can we not recognize that there are times and places where uniforms are indicated, and other times and places where they may not be necessary? Can we not demonstrate that we are members of an intelligent profession in our tolerance and consideration for what is most fitting and suitable for the nurse in her professional activity? – Lorraine F. Miller, R.N., P.H.N., Saskatchewan.

Tribute to Grace Fairley

The May issue contains an excellent tribute to the late Grace M. Fairley. As a graduate of the Hamilton General Hospital, I regret that an error was made in stating that Miss Fairley was "Superintendent of Nurses of the Montreal General Hospital from 1919 to 1924." She held this position at the Hamilton General Hospital during that period.

I consider it a privilege to have been one of Miss Fairley's graduates. I presume that others share my wish that her connection with "our" school is not omitted, and concur with Dr. Mussallem's statement that "Miss Fairley was one of the giants in Canadian nursing." – Mrs. Alberta Creasor, London, Ont.

Directory available

St. Boniface General Hospital Nurses' Alumnae has prepared an up-to-date directory of almost 2,000 former St. Boniface School of Nursing graduates. A copy may be obtained for $1.50 plus 20 cents to cover postage. Please direct requests to St. Boniface School of Nursing and make money orders payable to "Secretary, St. Boniface Nurses' Alumnae, St. Boniface School of Nursing. Proceeds will go to aid the scholarship fund. – Mrs. M. Isbell, St. Boniface General Hospital.

news

Ad Hoc Committee Completes Draft For Standards For Nursing Service

Ottawa. – The Canadian Nurses' Association's ad hoc committee on standards for nursing service met at CNA House June 4-6 to complete the draft for standards on nursing service. The committee produced a guide for evaluating nursing service, incorporating many of the suggestions offered by the participating health agencies.

Eight hospitals, ranging from 170 to 1,000 beds; three extended care facilities; four public health centers; four Victorian Order of Nurses' agencies; and three occupational health units took part in testing the draft. Directors of nursing, selected in areas where a member of the ad hoc committee was available for interpretation, received the drafts in April.

Included in the draft were: philosophy, objectives, functional structure of the nursing department, personnel, material resources, and the nursing department within the total organization. Participants in the study evaluated each of the standards in terms of clearness and conciseness, relevancy, flexibility, measurability, and attainability. Results of the draft testing indicate that the terms are generally applicable in all areas where nursing care is given.

The guide will be presented to the CNA Board of Directors for approval at the November meeting. Early in 1970 the nursing service evaluation guide will be available to CNA members.

Fran Howard, CNA consultant on nursing service, told *The Canadian Nurse* that the next phase of the study will be the development of standards for nursing care. The board of directors will be asked to restructure the ad hoc committee to include more people from the clinical area and nursing education, Miss Howard added.

The ad hoc committee on standards for nursing service was set up by the board of directors in March 1967. Two factors influenced its formation: 1. the results of a study conducted by Lillian Campion – at that time director of the CNA project for the evaluation of the quality of nursing service – that CNA initiate a program to assist those with administrative responsibility to study and evaluate their own departments; and 2. CNA's efforts to obtain representation on the Canadian Council of Hospital Accreditation and the need for CNA to have nursing service standards.

Gold Chain Honors Nurses



Charlotte Whitton presented a presidential gold chain of office to Sister Mary Felicitas, president of the Canadian Nurses' Association, in a special ceremony June 6 at CNA House. The medallion is engraved with the raised leaf and lamp symbol of CNA with "Canadian Nurses' Association des Infirmières canadiennes" printed around the edge. At Dr. Whitton's request, these words are engraved on the back of the medallion: "Given to honor the profession and three fine women and great nurses: Jean I. Gunn, Gertrude M. Bennett, Agnes J. Macleod."
The presidential chain has 25 links engraved with the names of the 25 presidents of CNA from its inception in 1908 to the present. A special case for the chain bears the plaque: "Presented by Charlotte Whitton, CBE, SM, 1969." In the presentation Dr. Whitton pointed out that the chain could be readily adapted to meet any anatomical variation in presidents.

RNABC Elects New Officers

Vancouver, B.C. – Results of the mail balloting for officers were announced at the 57th annual Registered Nurses' Association of British Columbia meeting in Vancouver May 21-23. Monica D. Angus of Port Coquitlam, B.C. was elected president of the 12,000-member organization.

In her acceptance speech Mrs. Angus said that the public is bringing increasing pressure upon governments to provide better health services and that the governments are making decisions regarding the provision of services. Mrs. Angus went on to say that this had implications for associations. "Governements are not equipped to make proper decisions regarding the quality and quantity of health care without the expert knowledge that only groups like ours can provide," she said.

Mrs. Angus is a graduate of St. Paul's Hospital, Vancouver, and holds a bachelor of science in nursing degree from the University of B.C. She recently completed requirements leading to a master of arts degree at UBC.

Other officers elected were: first vice-president – Roberta Cunningham, educational director at St. Paul's Hospital School of Nursing; second vice-president – Alice Baumgart, associate professor, UBC School of Nursing; honorary secretary – Sister Kathleen Cyr, su-

perior, trustee, and general duty nurse, St. Joseph's Hospital, Victoria; and honorary treasurer – Thomas J. McKenna, medical technician, Riverview Hospital, Essondale.

Nurses Negotiations With NBHA Deadlocked

Fredericton, N.B. – The New Brunswick Association of Registered Nurses' negotiation committee announced June 5 that negotiations with the New Brunswick Hospital Association had broken down. The committee has had six meetings with the labor relations committee of the NBHA since March 10 to negotiate salaries and working conditions for 1969.

Marilyn Brewer, spokesman for the nurses' committee, said that the breakdown resulted from NBHA's refusal to make a realistic offer to the nurses. Current 1969 salaries for registered nurses in New Brunswick are $373 per month, the lowest in Canada.

At a meeting held June 2, it was apparent that the NBHA committee had not given any consideration to the nurses' proposals made May 5, according to Mrs. Brewer. "Negotiations have been futile," she said, "because of constant changes in management representatives and lack of preparation on the part of management between meetings."

It is the committee's opinion that NBHA has not been bargaining in good faith, Mrs. Brewer explained. "We can only conclude that the Hospital Association and the government are not interested in improving the working conditions of nurses, which ultimately affect patient care," she added.

The nurses were willing to submit to compulsory arbitration in the event of a deadlock, but the hospital association would not agree. Arbitration is not compulsory since the Public Service Labor Relations Act of New Brunswick, passed in December 1968, has not yet been signed into law by the Lieutenant Governor-in-Council. The Act would give nurses the right to bargain collectively. In the meantime, nurses have been forced to accept an interim negotiating procedure with the NBHA as directed by the minister of health, Mrs. Brewer said.

"Today's nurses are dedicated people," Mrs. Brewer said, "but they will no longer meekly accept low scale salaries and working conditions for their services."

Letters registering disappointment and concern with the method and conduct of negotiations to date were sent to the president of the NBHA and the New Brunswick minister of health and welfare.

RNANS Considers Principles Of Curriculum Building

Halifax, N.S. – The graduate of a two-year nursing program has learned to generalize and is prepared for a beginning position in nursing, Kathleen Arpin, consultant to schools of nursing, College of Nurses of Ontario, advised the executive committee and the curriculum council of the Registered Nurses' Association of Nova Scotia, April 24-25. The curriculum council is a new group established to set standards and evaluate two-year diploma programs.

Miss Arpin discussed some principles of curriculum building. The blueprint should focus on horizontal and vertical progress with principles organized from the simple to the complex, Miss Arpin explained. A philosophy leading to objectives forms the foundation, she continued. The student should then be placed in an integrated situation, Miss Arpin suggested, with the incorporation of growth and development, communications, and legal aspects.

Montreal To Close English Language Hospital Schools of Nursing

Montreal, P.Q. – Montreal's five English-language hospital schools of nursing will admit their last classes of students in 1969. In 1970, nursing education in the province will be within the Collège d'enseignement général et professionnel (CEGEP) for nursing and preuniversity schooling. The General and Vocational College is the English equivalent to CEGEP.

Under the CEGEP plan, students with a high school leaving certificate or equivalent will choose between a three-year program at a CEGEP to obtain an RN, and a two-year program of biological sciences at a CEGEP, followed by three years of arts, science, and professional courses at a university to obtain an RN plus "what will probably be a B.Sc.N.," Mary Barrett, director of nursing education at the Jewish General Hospital, explained.

Teaching hospitals will continue to play an important role in nursing education and provide clinical experience for CEGEP students. It is expected that a hospital will become specialized in a clinical field such as obstetrics or neurosurgery, Miss Barrett said.

She referred to the good teaching job that hospital schools of nursing have done in their time. They are not equipped to teach the sciences and other subjects now increasingly important in the curriculum, Miss Barrett said. Nurses will be free to teach nursing because sociology and biology will be taught by CEGEP professors, she explained.

The Association of Nurses of the Province of Quebec will continue to control the CEGEP curriculum, and to set and administer registration examinations, Miss Barrett pointed out.

Dawson College, the first of the English-language general and vocational colleges will admit approximately 400 students in 1970, the number now admitted to hospital schools of nursing.

Twenty French-language CEGEPs have attracted many students. In 1968, 1,402 students were enrolled in CEGEP nursing programs. The first nursing courses within the general system of education were offered in 1967.

The quality of nursing care should be better, Miss Barrett believes, because CEGEP students will receive a more liberal education and will mingle with students from other disciplines.

Miss Barrett reminded nurses who feel threatened by the CEGEP system that over 100 years ago Florence Nightingale recommended that nursing schools and nursing care should function under different budgets and administrations.

AARN Membership Increases In 1968

Edmonton, Alta. – Active membership in the Alberta Association of Registered Nurses in 1968 was 8,391, a 10 percent increase over 1967, according to Doris J. Price, AARN registrar. Associate membership increased from 1,718 in 1967 to 2,100 in 1968.

In her report to the association's annual convention May 13-16, Mrs. Price said that 866 nurses were registered by reciprocity, exceeding initial registrants by 262. Thirty-seven percent of these nurses came from outside Canada, as compared to 36 percent in 1967.

Mrs. Price said that the rapidly increasing membership is reflected in an improved supply of nurses, chiefly in the cities. "With the trend to urban living," she said, "it continues to be very difficult for many hospitals in the rural areas to attract adequately prepared staff."

First Nurses Graduate From Memorial University

St. John's, Newfoundland. – Four registered nurses became the first baccalaureate graduates of Memorial University's School of Nursing on May 24. They were also the first to wear the coral velvet-edged hoods signifying the degree of bachelor of nursing.

Memorial University admitted its first class of nursing students to the five-year basic, integrated degree program in September 1966. Since the average age of high school graduate is 16 years, candidates for admission to the school of nursing are required to complete one year

of study at the university before being formally admitted to the professional program. This plan permits the student to enter the nursing program with the necessary academic prerequisites – English, psychology, biology, chemistry, and a language course – plus "a certain degree of maturity."

The decision to admit registered nurses to the school of nursing arose from the faculty's concern that there were many capable nurses in Newfoundland who desired higher education but who did not find ready access to mainland universities.

Admission is limited to resident registered nurses who entered hospital schools of nursing prior to the opening of the university school. The course in nursing is designed to ensure that all graduates from the school of nursing have met the same requirements. Registered nurses must complete the same requirements in arts and science courses as students in the basic program.

At the convocation exercises the senate of Memorial University awarded the honorary degree of D.Sc. to Helen K. Mussallem, executive director of the Canadian Nurses' Association. Dr. Mussallem is the first nurse to be honored by the university.

CMHA Approves Volunteer Services For Emotionally Disturbed Children

Toronto. – Approval in principle of a project providing school volunteer services for emotionally disturbed children was given by the National Scientific Planning Council of the Canadian Mental Health Association at its 21st annual meeting March 13.

The CMHA will also establish a special committee on the study and possible implementation of this project, and will consider methods of training, selection, supervision, and control of volunteers.

In a submission to the CMHA, Mrs. John Wickett described the volunteer program which has been operating in Ottawa since 1963. Volunteers are recruited to work on a one-to-one relationship with disturbed children. They visit the school at least twice a week and take the children out of the regular classroom. The volunteer aims to win the child's confidence, to restore his self-respect, and to assist with school work to the extent he is capable of learning.

Several other reports were presented at the annual meeting, including:

A report on a study to find out whether nicotinic acid is useful in treating schizophrenics. Although the study will not be completed for six years, enough evidence for or against the use of nicotinic acid will be available within three years for doctors to make up their minds whether or not to use it.

- The report of the Commission on Emotional and Learning Disorders of Children. The Commission recommends multi-disciplinary centers to focus on the individual, his needs, and ways to meet them. The Commission will be publishing its report within a year.

The CMHA also voted to commend the federal government for establishing a task force to study the mental health needs of Eskimos and Indians in the Yukon and Northwest Territories, and to offer to participate if requested.

A long discussion on the question of student unrest ended when it was decided the real need was to study the process of change and how people react to it in a university setting, rather than to study student unrest per se.

The Canadian Nurses' Association representative at the annual meeting was A. Isobel MacLeod who is director of nursing at The Montreal General Hospital and a past president of CNA.



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"Too Many Supervisors" RNABC Meeting Told

Vancouver, B.C. – "The bedside nurse needs more freedom to practice as a professional. Get rid of the needless brass at the top and let the pure gold of our nursing practitioners shine through."

These were the concluding remarks of the keynote speaker at the 57th annual meeting of the Registered Nurses' Association of British Columbia, May 21-23.

Speaking on structure of nursing services in the hospital, Margaret D. McLean, a nursing consultant for the federal government, told the audience that hospital nursing staffs were top heavy with brass. In the pre-Second World War period, when most nursing care was given by student nurses, there was a need for several levels of supervisory personnel, she said. However, she added that nursing education and service have changed and that now bedside care is the responsibility of the well-prepared, general duty staff nurse.

"But the same structure still exists in the nursing service hierarchy," she added.

Miss McLean, who is senior consultant, health insurance, Department of National Health and Welfare, described projects at several hospitals that have started to look at the structure of nursing service so that it can be streamlined.

During the three-day meeting, delegates passed a resolution calling for the RNABC to establish criteria for the standardization of courses on intensive care and coronary care.

Another resolution called for the RNABC to investigate the need to raise the annual registration fee and to revise fee rebates to chapters and districts.

Registration for the meeting was 363.

CHA To Study Nursing Education

Ottawa. – Provincial delegates to the second national convention and assembly of the Canadian Hospital Association meeting, May 21-23, adopted a resolution to conduct a study of the results being achieved in nursing education.

A lively discussion among the delegates followed the reading of the resolution before it was finally accepted by the assembly. A debate developed concerning whether or not there should be a study.

An Ontario delegate expressed concern about the cost of a study. Dr. H. Dalgleish, president of the Canadian Medical Association, spoke in opposition to the resolution. "The study is too soon," he said. "We must move very cautiously in this area."



Time out at the Canadian Hospital Association convention in Ottawa in May. Pamela Poole, nursing consultant Department of National Health and Welfare, chats with a Health and Welfare colleague, Dr. Roger-B. Goyette, director of Hospital Insurance and Diagnostic Services. Earlier they heard Dr. Bernard Snell discuss The Teaching Hospital and Research.

An Ontario delegate, herself a nursing director, also questioned the validity of the study. "How can you get a just evaluation when there is dissension between nursing education and nursing service? "

A delegate from Saskatchewan commented that her province would not be in a position to help evaluate nursing programs because nursing education there is now under the department of education. Chaiker Abbis, Q.C., chairman of the assembly, pointed out that the intent of the study is not to tell nursing what to do, but to offer comments and evaluation. R. Alan Hay, CHA president, reminded the assembly that the CHA "evaluates as an employer."

Several delegates supported the nursing education study because of their concern about the effectiveness of a graduate from a two-year program as compared to the graduate from a three-year program.

The structure of the committee that will conduct the study also was discussed. Sister Raymond Marie, an Ontario delegate, asked if there would be a nurse represented on the committee. She received a negative reply from the chairman.

Several delegates supported the view that the study should be conducted independently of doctors and nurses. Other delegates said that the study should be conducted in collaboration with the Canadian Nurses' Association. Dr. H.J. Warwick, a delegate from Newfoundland, spoke in support of CNA representation on the study committee. He said, "The CHA should include CNA and other allied groups, but we are against CNA official representation."

A nurse delegate from British Columbia and a delegate from Quebec expressed the opinion that CNA would appreciate CHA's opinion. L.R. Adshead, installed as the new CHA president May 22, made his views known on CNA participation. "The CNA supposedly represents 80,000 nurses," he said. "CNA is poppycock."

This will not be the first study on nursing education conducted by CHA. A previous study resulted in the publication in 1967 of *Viewpoint on Nursing Education,* in which CHA stated that new programs in nursing education should be developed on an experimental basis only. In addition the statement said that any attempt to phase out existing nursing education programs before an acceptable substitute had been developed could jeopardize the quantity and quality of nursing care and constitute a serious threat to the hospital care of the sick.

Following the issuance of CHA's statement in 1967, Sister Mary Felicitas, president of the Canadian Nurses' Association, said, "The CNA is amazed that the Canadian Hospital Association could arrive at such a statement without a single registered nurse on the committee responsible for drawing it up."

"Organize Resources" Minister Tells CHA

Ottawa. – Health Minister John

Munro cautioned delegates at the second national convention of the Canadian Hospital Association May 21, that if hospitals and other health facilities did not get together to coordinate their services, then he and his provincial colleagues would give serious thought to the selective use of government funds to reach that goal themselves.

The team principle is coming into more general operation, Mr. Munro said, and hospitals have a crucial role to play. "Perhaps we should be thinking in terms of the hospital as a community care center," he suggested. The first step would be a counseling service that should stretch into the community where people could discuss their health problems and decide if they needed care, Mr. Munro advised.

Active treatment is important, Mr. Munro said, but community care centers should have intensive rehabilitation units as well. Mr. Munro believes that there should be a variety of types of treatment: continued hospital care; convalescent care; skilled nursing care; and coordinated home care. Since not all illnesses are physical in nature, health workers must consider establishing comprehensive community mental health services, the minister pointed out.

We need integrated facilities efficiently planned on a broad scale, Mr. Munro said. Competition among hospitals is senseless and often harms the overall community health picture, he warned his audience. We must plan so that existing facilities are used to the best advantage, thus avoiding excesses on the one hand and shortages on the other.

He added that in his view we must provide the same standard of health care for all Canadians – the poor, the disadvantaged, and the Indians – "instead of simply pyramiding and sophisticating what the haves of our society already possess."

Mr. Munro referred to the work of the student health organization of the University of Toronto (SHOUT), a group that attempts to unite students from the various health sciences in a team project. These students have established a center to send workers into the community for follow-up visits to people who have been to their center. Mr. Munro said that SHOUT is an attempt to create a meaningful society in miniature.

The minister challenged his audience by asking if the requirements for certain health care occupations and service groups were too rigid.

In conclusion, Mr. Munro recommended that if part of the hospital's responsibility includes a poverty area in a major city, then representatives of the poor should sit on that hospital's board. "After all, who knows the health problems of our urban slums and ghettos better than those who have had to live there? " he asked. "Trusteeships should not be allocated on the basis of whose name would add the most status to a letterhead," the minister said.

Health Care For Remote-Area Indians

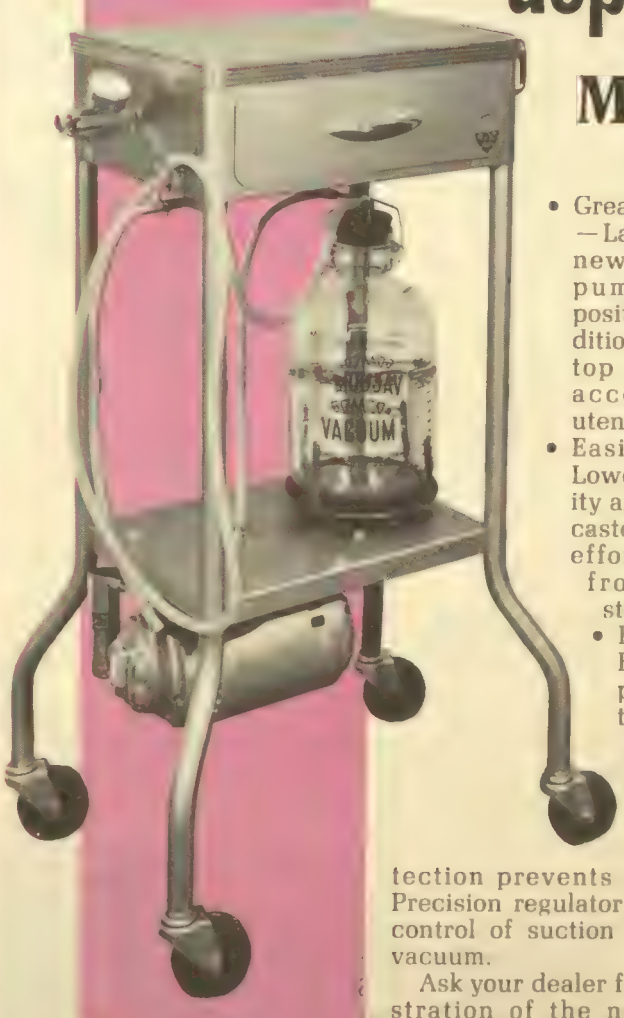
Toronto, Ont. – Doctors from the Faculty of Medicine at The University of Toronto will provide health care for 15,000 Indians who live in the Sioux Lookout Zone. This informal undertaking is sponsored by the federal government.

The program will be coordinated by Dr. Harry W. Bain, chairman of the department of pediatrics, University of Toronto, and chief of pediatrics at The Hospital for Sick Children. It should increase the number of general practitioners and specialists available to the area.

The current project has its origins in a letter, written by Dr. Bain last May on behalf of The Hospital for Sick Children,

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which offered to the federal government the assistance of the staff and resources of the hospital in providing care for Indians and Eskimos. The response of Federal Health and Welfare Minister, the Hon. J.C. Munro, was immediate and enthusiastic.

"It is hoped," Dr. Bain said, "that nursing, whether from hospital training schools or the university department, will look carefully at this project with a view to providing not only service to Indians of the area but also training for their undergraduates and research into the need for training doctor-nurse associates."

Emergency Hospital Institute Displays Instant Hospital

Ottawa. – An Emergency Hospital Institute held April 21-23 to familiarize professional health personnel with the kinds of emergency equipment available, attracted nearly 2,000 health workers and students. It was the ninth Institute in a series sponsored by the Emergency Health Services branch of the Ontario Hospital Services Commission. The emergency hospital in operation was the central theme of the institute.

The emergency hospital is prepackaged and contains sufficient supplies and equipment to care for 200 persons injured during explosions, floods, tornadoes, fire, or nuclear warfare. It reinforces the casualty care services provided by an existing hospital.

The hospital was displayed as it would be used in an emergency situation. Supplies and equipment are provided for seven days and, with additional supplies from the national medical stockpile, extend a hospital's function to 30 days.

Each of the eight general wards are equipped to care for 20 patients. In addition, two wards are available for preoperative and postoperative care. Twenty nurses and 51 nursing assistants would provide nursing care for these patients. All personnel would be prepared to accept responsibilities beyond ordinary practice.

The lightweight folding beds have decks of nylon and cotton coated with plastic. Two wool and synthetic fiber blankets, a patient's effects bag, and a pillow covered with a plastic pillow slip are provided for each bed.

Other aspects of the display included x-ray equipment, central supply with special autoclaves, oxygen and suction equipment, and pharmacy.

In 1966, the emergency hospitals were put to practical use when 20 were supplied under the auspices of the Colombo Plan to South Vietnam. Dr. W.J. Connelly, medical consultant emergency health services, Department of National Health and Welfare, and Mr. M.J. Corbeil, packaging officer, health supplies section, emergency health services, Department of National Health and Welfare, made several visits as consultants to the Vietnamese Ministry of Health to discuss the installation and operation of the emergency hospital units.

Fear Of Malpractice Suits Reaches Canadian Nurses

Toronto, Ont. – "Nurses and doctors are infected with fear from the U.S. as far as lawsuits are concerned," Dr. T.L. Fisher, secretary-treasurer of the Canadian Medical Protective Association in Ottawa, told 1,100 members of the Registered Nurses' Association of Ontario at the first day session of the annual meeting at the Royal York Hotel, May 1-3.

"Canadians are sensitized to American thinking and this is wrong," Dr. Fisher said. "Much of the advice to U.S. professional persons is inapplicable and misleading." Dr. Fisher said that to the best of his knowledge no nurse in Canada has ever been held personally and solely responsible in legal action without the employer being included.

Although nurses in the U.S. are advised to carry malpractice insurance, Dr. Fisher does not believe this is necessary for all Canadian nurses. Most hospitals in Canada carry malpractice liability insurance that covers all their employees including nurses, he explained. The case of the "too hot hot water bottle" was cited as an example for which both the nurse and the hospital can be held responsible in legal action.

Today, nurses are being pushed into new fields of work by a variety of forces, Dr. Fisher explained. There are new medical procedures and doctors must now delegate new responsibilities to nurses, he said. The nurse can be guilty of negligence if she allows others to think that she has been taught to carry out a particular procedure, carries out the procedure, and makes an error, Dr. Fisher cautioned.

The nurse's duties in the recovery room and the intensive care unit are more onerous since she is working under conditions of urgency and stress, Dr. Fisher believes. Here, nurses need more training and some legal reasoning. "The nurse should make sure that she has adequate training and experience and subject herself to testing by a qualified person," Dr. Fisher said. "She has a duty to acquire sufficient skill and to use knowledge with reasonable care."

In a legal action the nurse must show that "knowledge and skill were used with reasonable care," Dr. Fisher explained. "Canadian courts do not demand perfection, but they do insist on competence." Dr. Fisher said that the courts are about as sensible as the rest of us. "They will not penalize merely because the outcome of treatment was poor; not all treatment can cure and Canadian courts do not demand the impossible," Dr. Fisher assured his audience.

Under special circumstances a nurse must use discretion. Dr. Fisher gave administration of medication as an example: a nurse knows or should know when a dose is too high and the effects of the drug she is giving. "The nurse has a right and a duty to confirm a dose or to say that she prefers not to administer the drug because her knowledge is too slight," Dr. Fisher advised. In this case the nurse is "simply avoiding something that was ill-advised," he explained.

Although Dr. Fisher did not support malpractice insurance for all nurses in Canada, RNAO voting delegates approved the resolution "that the Association engage in a group policy for malpractice insurance with voluntary participation by RNAO members." The cost was estimated at $2.50 for each participating member per year.

A Moral And Legal Look At Organ Transplants

Ottawa. – Moral and legal problems that face organ transplant donors and recipients, their families, and the medical team are not isolated issues. This was illustrated vividly by two speakers who addressed the final session of the Canadian Hospital Association's second national convention and assembly May 23.

The Reverend Dr. Paul McCleave, director of the department of medicine and religion for the American Medical Association, warned delegates that organ transplants are always a risk and "are not something for society, in its emotion, to praise or reject."

Dr. McCleave expressed his concern about the publicity that surrounds persons involved in heart transplants. He pointed out that there is no moral issue in the heart transplant that is any different from any other organ transplant. "One reason why the press has taken over on heart transplants," he explained, "is that for so long the heart has been used as a symbol of compassion, mercy, etc. It is necessary to change society's attitude toward the body, which is not sacred."

Destroying privileged communication is immoral, Dr. McCleave said. He expressed concern about the growing practice of making public information about heart transplant patients and donors. As an example of this, he told the audience about a man who, suddenly faced with the news that his daughter had irreversible brain damage, said "no" to having her

heart transplanted; immediately his name, as well as the disappointment of the transplant team, was known across the United States. "It was nobody's damn business," Dr. McCleave said. "I don't know what I would say in a moment of emotion."

H. Allan Leal, Q.C., chairman of the Law Reform Commission, Toronto, outlined proposed South African legislation, which, if enacted, would be the first law to prevent disclosure of the identity of the transplant donor or recipient, unless authorized by the families involved. "This legislation," Mr. Leal said, "would plug loopholes that exist in our legislation." Mr. Leal explained that the South African bill also deals with the difficult problem of avoiding conflict of interests in determining the time of death. This would be determined by two medical practitioners who are not part of the subsequent medical team.

Dr. McCleave believes there are three stages of death: 1. cellular death; 2. physiological death; and 3. the loss of "meaningfulness" that does not necessarily take place at the time of physiological death, but when the individual "as a being" no longer exists.

Public Health Nurses Return To Work

Toronto, Ont. – The 18 public health nurses of the Grey-Owen Sound Health Unit who went on strike for higher salaries April 18 returned to work June 2. They agreed on a one-year contract effective from January 1969 to December 1969 with the right to renegotiate three months prior to the end of that contract.

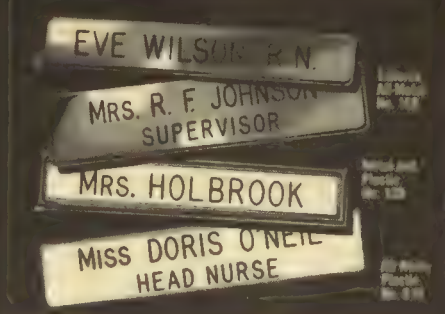
Compromises concerning salaries were made on both sides. If the contract is ratified by Grey County Council, public health nurses will receive a salary ranging from $6,000 to $7,250. This represents an 11 percent increase over the salary range previously in effect.

At issue was Grey County's share of the increase in salaries asked by the nurses and approved by the province of Ontario and the City of Owen Sound, who, with Grey County, share the costs for the Grey-Owen Sound Health Unit. Grey County, whose share represents less than one-fifth of the total, had insisted that the 1968 scale continue for another two years into 1971.

The public health nurses, who are required to have the minimum of a university diploma, had been paid at a rate $240 a year less than the Ontario Hospital Service Commission's approved salary rate for newly graduated registered nurses.

At press time the Grey County Council had not yet ratified the contract with the nurses.

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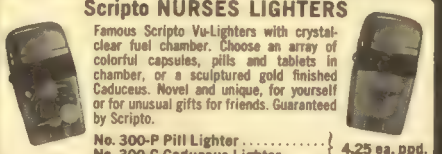
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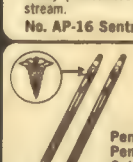
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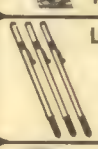
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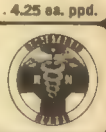
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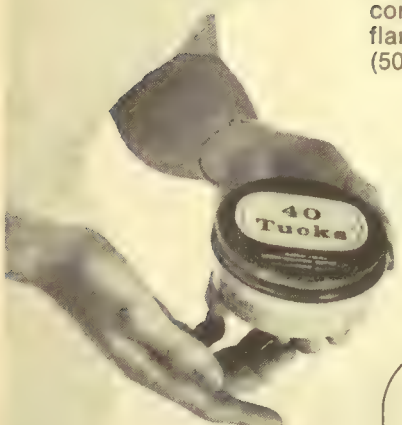
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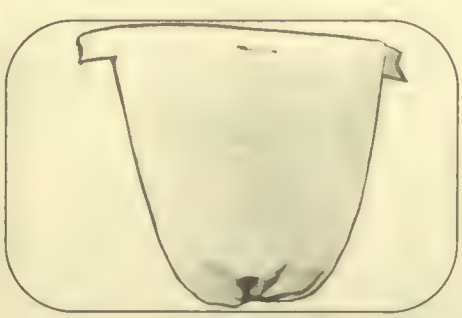
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news

Orderly Training Program To Open In BC In Fall

Vancouver, B.C. — British Columbia will open its first training program for orderlies this September. The new program, which will be held at a technical school in Victoria, was announced at the annual meeting of the Registered Nurses' Association of British Columbia meeting in Vancouver in May.

According to Helen Saunders, one of two RNABC representatives on the planning council for the new program, the new nursing orderly course will be roughly equivalent to BC's one-year practical nurse program, although the new program will take only 10 months. It is expected that the orderlies' program will place less emphasis on maternity care and will stress male genitourinary treatments, orthopedic care, and inhalation oxygen therapy.

Miss Saunders told *The Canadian Nurse* that the RNABC has long supported some kind of training program for orderlies. "We wanted a pre-service training, not an inservice training," she said.

She thought that the new program would be a valuable beginning.

"The RNABC would like to see the orderlies' program and the practical nurses' program basically parallel because of the similar nature of the work of the two in hospitals," she added. "We do not see any reason to add a new category of health worker only on the basis of sex."

Hospitals will have no legal pressure to hire only the trained nursing orderlies, but the program is supported by the BC Hospital Association and the BC Hospital Insurance Scheme; the local unit of the orderlies union has also promoted the idea.

Miss Saunders said she thought that many young men might enter the orderlies' program even though they had the background for entrance to a school of nursing. "If the pay remains as good, and the separate categories continue, why not? " she asked. She said that in many instances orderlies' pay is comparable to that of an RN.

Male Student Wins Recruitment Poster Contest

Vancouver, B.C. — Who'd know more about how to recruit students into nursing than students themselves? At least, that's what the Registered Nurses' Association of British Columbia must have thought when it decided to sponsor a poster contest with a $50 prize for the best poster aimed at recruitment of stu-

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dents into nursing programs.

Grant Dickinson, 23, a preliminary student at The Vancouver General Hospital School of Nursing, won first prize in the contest. Contest winners were announced by Margaret H. Lunn, RNABC's retiring president, at the 57th annual meeting May 21-23. Mr. Dickinson won the $50 prize for submitting the best poster aimed at recruitment of students – male and female – into nursing. He received a bachelor of arts degree in anthropology from Simon Fraser University last year, prior to entering the nursing program.

The second prize of $25 was won by Elizabeth Maria Ottens, 21, a student in the class of 1970 at the Royal Inland Hospital School of Nursing in Kamloops.

Honorable mention was awarded to Gerdina Tolen, a student in the class of 1970 at St. Joseph's Hospital School of Nursing in Victoria, for one of two posters she entered in the contest.

Contest judges were Peter Small, a Vancouver artist; Lisa Goscoe, representing the Student Nurses' Association of British Columbia; and Claire Marcus, director of communication services for the RNABC.

Canadian Red Cross Establishes Nursing Fellowship

Toronto, Ont. – The Canadian Red Cross Society has announced the establishment of a Red Cross National Nursing Fellowship. It will award $3,500 annually, or may accumulate to $7,000.

The resolution was passed unanimously by the Central Council of the Red Cross May 6, after studying a report prepared by Helen M. Carpenter, honorary adviser in nursing. The report, presented May 4, recommended the establishment of a $3,500 fellowship. The Central Council changed the motion to allow the fellowship to accumulate to $7,000.

Royal College Of Nursing Against Voluntary Euthanasia

London, England. – The Council of the Royal College of Nursing adopted a policy in April that opposes proposed legislation to permit voluntary euthanasia. The Rcn believes that the practice of euthanasia is contrary to the ethical principles of the medical and nursing professions.

The British Medical Association and the World Medical Association both agree "that the practice of euthenasia is contrary to the public interest and to medical ethical principles as well as to natural and civil rights." ☐

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Holds patient upright on commode, straight-back, or wheelchair; prevents slumping for ward. Secures patient to commode with safety, privacy and without nurse's constant supervision. Shoulder straps may be used in the front, straight over the shoulders or criss-crossed. Adjusts to fit virtually all patients. Cat. No. 4220. $14.85 each.



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A friendly restraint available in infant, small, medium and large sizes. Also widely used for holding extremity during intravenous injection No. P-450, $6.00 per pair, $12.00 per set. With DECUBITUS padding, No. P-450A, $7.00 per pair, $14.00 per set.

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names



Judith Whitaker, executive director of the American Nurses' Association, visited CNA House May 12. Mrs. Whitaker (left) and Dr. Helen Mussallem, executive director, Canadian Nurses' Association, took a few minutes after a press conference at CNA House to read the article "Do Your Own Thing in Montreal" in the May issue of *The Canadian Nurse.*



Marjorie Duvillard, an internationally known Swiss nurse, has been appointed deputy executive director of the International Council of Nurses. She has special responsibilities for coordinating the professional activities of nurse advisers.

Born in Argentina, Miss Duvillard received her basic nursing training at Le Bon Secours Hospital school of nursing in Geneva. She obtained a diploma in public health nursing from Geneva's Ecole d'Etudes Sociales, and took postbasic nursing education in the United States at Western Reserve University, Cleveland, Ohio, and at the University of California, San Francisco.

Throughout her career Miss Duvillard has taken an active interest in nursing in many countries. She was the Latin American representative for two years for the International Union for Child Welfare in Geneva. For three years she was nurse adviser for Latin America at the League of Red Cross Societies.

Miss Duvillard has worked closely with the World Health Organization. She is a member of the board of the International School of Advanced Nursing Education in Lyon, France, and a member of the International Committee of the Red Cross.

Marjorie Duvillard was formerly director of Le Bon Secours school of nursing in Geneva. Before assuming her new position, she visited several Latin American countries as an ICN consultant.

One year after receiving an honorary Doctor of Laws degree from the University of New Brunswick, **Helen K. Mussallem,** executive director of the Canadian Nurses' Association, was back on the east coast to receive an honorary Doctor of Science degree from Newfoundland's Memorial University.

The citation that was read for Dr. Mussallem, noting that the first degrees in nursing were being awarded at the university, called this a fitting occasion to honor "one who contributed with her vision and her energy to the foundation of our School of Nursing and who, in her own career, has set a model to the profession."

In the citation, tribute was paid to Dr. Mussallem's doctoral thesis on Nursing Education in Canada, published in 1962, that "has become a basic handbook in Canada, along with her *Spotlight on Nursing Education* published in 1960. *Spotlight* is a report of a pilot project for evaluating nursing schools, and in compiling it Helen Mussallem traveled thousands of miles by incredibly various and unpredictable transportation, visited unheard of places . . . traveling in darkest Canada. . . .

"A measure of her effectiveness may be seen in the statistics on Canadian nursing: the spectacular growth of recent years in the number of nurses with bachelor's degrees, with M.A.'s, and doctorates."



Jean C. Leask (B.A., Reg.N., U. of Toronto; M.A., U. of Chicago) is the 1969 recipient of the R.D. Defries Award. The award is given by the Canadian Public Health Association for outstanding contributions in the field of public health. Miss Leask is director in chief for Canada of the Victorian Order of Nurses.

Miss Leask was born in Moose Jaw, Saskatchewan, and on graduating from nursing she joined the VON in Toronto. She was transferred to Regina as nurse in charge in 1940, when she was given a traveling fellowship by the Rockefeller Foundation. She traveled through the United States and Canada, observing official agency programs for a year.

In 1942, Miss Leask returned to Toronto as supervisor, and was promoted to assistant district director in 1943. She remained until 1952.

After receiving her M.A. degree in 1953, she returned to Toronto as staff nurse and assistant director of the City of Toronto's Department of Health. In 1960 she returned to the VON as director in chief for Canada, the position she now holds.

Miss Leask has earned other awards during her career. In 1965 she was admitted as Officer Sister of the Order of St. John; in 1967 she was awarded the Centennial Medal. She is a member of the commission to study the structure of the Canadian Public Health Association.



Jean L. Church, former president of the Registered Nurses' Association of Ontario, died in Ottawa May 30.

Miss Church graduated from the Toronto General Hospital in 1925, and went to the Homeopathic Hospital in Montreal (now the Queen Elizabeth Hospital) as night supervisor in 1928, later becoming floor supervisor. Then she turned her interests toward private duty nursing.

Miss Church's contributions to RNAO began when she became chairman of its private duty section, and later chairman of the Canadian Nurses' Association's private duty section. She was second, then first vice-president of RNAO, before becoming president in 1940. She held that position for two years.

During Miss Church's term as president, the community nursing registry program was started and a registry supervisor appointed. Special studies were made of private duty nursing. It was also during her term that RNAO began an experiment in the training of nursing assistants by sponsoring eight courses of six-month periods. The Ontario government continued the programs at the end of the eight experimental courses, and the result is the nursing assistant program as it is today. □

new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.

Improved Facemask

The Bardic facemask now features an adjustable nose band that is easily shaped to conform and hold to individual facial contours, effectively reducing breathing leakage. The improved cloth tie strings provide a more comfortable fit and are easier to tie.

The facemask is made of a filter material of fine fibers that capture and hold 96 to 99 percent of aerosol bacteria and effectively remove viral particles. The deep fold across the mask helps provide a snug fit and forms an air chamber to contain breath until filtered. The soft, nonwoven fabric covering is smooth and non-irritating, and the OR green color reduces glare and reflection.

This facemask is available in a 50-mask dispenser that permits removal and donning of the mask with minimal handling.

For literature, write C.R. Bard (Canada) Ltd., 22 Torlake Cres., Toronto 18, Ont.

Gas Aerator

This gas aerator, which removes absorbed ethylene oxide gas from heat and moisture sensitive materials following sterilization, reduces to one-third the time established for ambient temperature aeration.

Thermostatically controlled heating elements, bacteria-retentive filter, and dual blower fan provide four complete heated chamber air changes every 60 seconds. The unit operates automatically. The operator sets the timer; presses the power switch; and the gas aerator automatically times the cycle, heats the chamber to 120°F, and aerates the load with heated, filtered air.



Gas Aerator

The aerator, when mounted adjacent to a gas sterilizer, forms an efficient installation for fast, safe, gas sterilization. This gas aerator is for use principally in central supply, inhalation therapy, and urology departments – wherever heat-and-moisture sensitive materials are gas sterilized.

Address inquiries to: American Sterilizer Co. of Canada, Ltd., Brampton, Ont., for Catalog SC-347.

"Niftee" Toothbrush

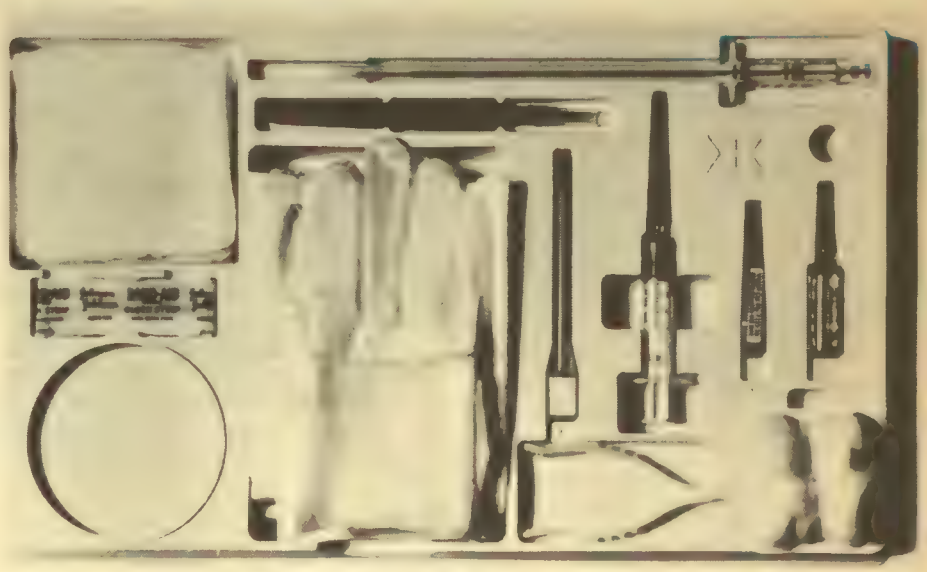
"Niftee," a toothbrush with toothpaste in the bristle, eliminates problems for patients who enter hospital without toothbrushes. Each Niftee is individually cello wrapped with the toothpaste impregnated in the professionally approved nylon bristles. The brush is full size, disposable or reusable with regular toothpaste.

For further information write to: Lind Equipment Ltd., 37 Colonsay Road, Thornhill, Ont.

Disposable Biopsy Tray

This completely disposable biopsy tray contains all the necessary equipment to perform a biopsy procedure.

The components of the tray are arranged according to the sequence in which they are used. A special inner and outer wrap ensure the sterility of the tray.



Baxter's Disposable Biopsy Tray.

The prep dish in the tray is divided into two halves: the smooth side is used for macroscopic investigation and, if necessary, the serrated half is used for cutting specimen.

A featured item in the biopsy tray is the "Tru-cut" biopsy needle; it penetrates like a needle and cuts like a scalpel. The needle's 20mm notch holds the specimen, which is cut from surrounding tissue, rather than torn. The specimens obtained in this manner tend to be clean and precise.

Further information is available from: Baxter Laboratories of Canada, Limited, 6405 Northam Drive, Malton, Ont.

Raised Toilet Seats

A raised toilet seat has been introduced to help the handicapped for whom a standard height toilet is too low. This seat fits all standard toilets. The normal lid and seat are lifted and the raised toilet seat is fixed to the bowl by heavily chrome-plated bracket clamps. A fifth support bracket provides stability by preventing the seat from tilting forward.

This polypropylene raised toilet seat can be cleaned with boiling water. It is comfortable and increases the seat height by five inches at the front and six inches at the back. This lightweight unit can be lifted off when not in use. It is suitable for all standard toilet pedestals.

For further information write to: Everest & Jennings Canadian Ltd., P.O. Box 9200, Downsview, Ont. □

Next Month
in

The
Canadian
Nurse

- ICN Congress Report
- Private Practitioner and the Public Health Nurse
- Health Sciences Complex at Laval



Photo credits for July 1969

Murray Mosher, Ottawa, pp. 7, 10

Julien LeBourdais, Toronto, pp. 26, 27, 28

University Hospital, Saskatoon, p. 31

dates

August 1968 - June 1969
The National League for Nursing is sponsoring a series of 12 two-day workshops in several U.S. cities for persons involved in administration, planning, and evaluation of hospital nursing services. The first workshop was held in San Francisco August 9, 1968, and the last will be held in Miami Beach, June 26-27, 1969.

The workshops are designed for nurses and others interested in nursing audits, new staffing patterns, and hospital staff development programs.

Further information and application forms for registration may be obtained from the Department of Hospital Nursing, National League for Nursing, 10 Columbus Circle, New York, New York 10019.

August 18-21, 1969
American Hospital Association, International Amphitheater, Chicago.

September 18-20, 1969
Annual conference on obstetrics, gynecologic, and neonatal nursing, Sheraton-Brock Hotel, Niagara Falls, Ontario. Sponsored by District V of the American College of Obstetricians and Gynecologists.

September 23-25, 1969
10th annual meeting and convention of Associated Nursing Homes, Inc., Sheraton-Connaught Hotel, Hamilton, Ont.

September 25-27, 1969
3rd annual postgraduate course for emergency room nurses, Palmer House Hotel, Chicago. Tuition fee: $60. Write to: Dr. Anast, 55 East Washington Street, Chicago, Illinois 60602.

September 28 - October 3, 1969
13th annual Registered Nurses' Association of Ontario Conference on Personal Growth and Group Achievement, Delawana Inn, Honey Harbour, Ont.

October 6-8, 1969
Annual nurses' convention, sponsored by the American College of Obstetricians and Gynecologists, Marlborough Hotel, Winnipeg. For further information write to: Mrs. Jordan, c/o Women's Pavilion, Winnipeg General Hospital, 700 William Avenue, Winnipeg 3, Man.

October 6-8, 1969
Annual conference on obstetrical and gynecological nursing, sponsored by District VI of the American College of Obstetricans and Gynecologists. To be held in the Marlborough Hotel, Winnipeg. Nurses from all over Canada are welcome.

October 16-17, 1969
Continuing Nursing Education Course in Nursing the Adult with Long Term Illness. The University of British Columbia, School of Nursing, Vancouver, B.C.

October 24, 1969
Catholic Hospital Conference of Ontario Nursing Committee meeting, Westbury Hotel, Toronto.

October 25-26, 1969
Catholic Hospital Conference of Ontario, annual convention, Westbury Hotel, Toronto, Ontario.

October 27-28, 1969
Ontario Hospital Association, 45th annual convention, Royal York Hotel, Toronto.

October 30-31, 1969
Continuing Nursing Education Course in Pediatric Nursing. The University of British Columbia, School of Nursing, Vancouver B.C.

November 10-14, 1969
Course in occupational health for nurses, New York University Medical Center. This course, for registered nurses in industry, is offered by the department of environmental medicine of New York University, in cooperation with the American Association of Industrial Nurses. Tuition: $175. The course is limited to nurses with five years or less experience in occupational health. Write to: Office of the Recorder, New York University Post-Graduate Medical School, 550 First Avenue, New York, N.Y., 10016.

November 11-13, 1969
Quebec Operating Room Nurses' Group, annual convention, Skyline Hotel, Montreal.

November 13-14, 1969
Continuing Nursing Education Course in Nursing the Adult with Acute Illness. The University of British Columbia, School of Nursing, Vancouver, B.C.

November 19-21, 1969
Second Manitoba Health conference, Fort Garry Hotel, Winnipeg. This was formerly the Manitoba Hospital and Nursing Conference.

November 24-27, 1969
Conference for directors of nursing, Toronto. Sponsored by Ontario Hospital Association and Registered Nurses' Association of Ontario. □

in a capsule

Study needed?

Delegates at the Canadian Hospital Association's annual convention in May approved a resolution that directs CHA to conduct its own study of the results being achieved in nursing education. Perhaps the time has come for the Canadian Nurses' Association to conduct a study to assess the results being achieved in hospital administration and in programs that prepare hospital administrators.

I.Q. deters smoking

Here is good news for those who are about to stop smoking. A new product to help break the smoking habit has been developed by the Chemway Corporation, Wayne, New Jersey.

Called "I.Q." – for I Quit – the smoking deterrent is a lozenge that comes in different flavors and is contained in a cigarette-like package. According to the manufacturer, a lozenge "popped into the mouth when the smoker feels the urge to light up" reduces the desire to smoke.

Laugh and live longer

The German Society for Dental Health has discovered a good reason for laughing: the increased oxygen intake results in a more lively metabolism, more intensive breathing, and a relaxation of the diaphragm.

The society supports its theory with the evidence that women live longer than men – and women laugh more. It believes there is a correlation between these two facts.

On the basis of the above study, some practical advice to those suffering from laugh inhibition is: take in some big gulps of air (as in laughing) and relax the diaphragm (without collapsing) which reduces tension and increases sociability (moderation is advised).

Thus a laugh = a more lively metabomism = a more lively day (or evening).

Telephone visiting chain

The Victorian Order of Nurses in Kingston, Ontario, has helped launch a telephone visiting chain to check daily on elderly people living alone. Five or six of these people, with a captain in charge, make up the chain. Each member of the "chain gang" is given a schedule of names and phone numbers in the order and time of calls. If a member cannot reach a number, he calls the captain. The member then calls the next person on the list, so that the chain isn't broken.

Another chain has been successful in Leaside, Ontario. The VON gives Sweden credit for the idea.

Equality for men

The traditional women's auxiliary at York-Finch General Hospital, Downsview, Ontario, is being replaced by a Volunteer Service Organization (VSO). Members of the other sex will be encouraged to join and will be able to supply transportation services, visiting services for men, and may help out in a planned translation service.

The VSO also hopes to attract members who are retired but still active.

Apart from providing services, the VSO will be a link between the hospital and community. Mrs. Lorraine Deane, VSO chairman, explains that hospitals are vital to their communities and everyone has a stake in them.

Volunteers already number 150 at York-Finch, although more are needed.

Pastels are "in"

Nurses in the pediatric ward at the Prince George Regional Hospital in British Columbia are working toward developing a warmer rapport with their young patients – by wearing pastel-colored uniforms.

The psychology behind this colorful move was well summarized in the *Prince George Citizen:* "A lot of kiddies develop a terrible fear of white, coming to associate it with pain," explained Mrs. Tom O'Hearn, supervisor of the pediatric ward. To a sick child in the hospital, nurses become associated with their painful stay. The resulting fear of the nurse can be transferred later in life to others wearing similar uniforms.

The swing from the white starched look to color has also taken place in the pediatric department of the Vernon Jubilee Hospital, Vernon, B.C.

Are nurses dressed in colored uniforms really friendlier or is it just the appearance that counts?

How to enjoy retirement

You can now go to school to learn "how to retire – and enjoy it." The Collegiate Institute Board of Ottawa sponsored this 10-week evening program. Among the topics covered were housing, leisure, hobbies, pension and insurance benefits, increasing income, personal investments, physical and mental health.

With this type of education, perhaps such expressions as "killing time" will disappear. Yet how many people would love to find out what it means to "kill time!"



"Dick Tracy uses a bedpan, Batman uses a bedpan . . . "

THIS MESSAGE WILL BE OF SPECIAL INTEREST TO:
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DIRECTORS OF NURSING SERVICES
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AMSCO PATIENT CARE CONSOLE


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Clean, uncontaminated patient utensils are essential to any hospital or nursing home's patient care program. In developing and improving these programs, most institutions look to Amsco . . . for we offer the most complete range of UTENSIL PROCESSING equipment and techniques available.

Whether your technique involves a simple, direct processing of individual patient utensils on the nursing floor . . . semi-automated or fully automated processing . . . even terminal sterilization in Central Service, Amsco has the equipment to implement it.

We consider patient comfort too. For example, our *Patient Care Console* is a practical method of rinsing and storing utensils right in the patient's bathroom . . . *and it warms them to a comfortable temperature.*

Amsco will help you institute the utensil technique of your choice . . . we have the full range of equipment and know-how to do it.

Write for UTENSIL PROCESSING literature.

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AMSCO PRODUCTS ARE MADE IN CANADA . . . FOR THE ADVANCEMENT OF THE WORLD HEALTH SCIENCES

Needed: a full-time lobbyist

• *Item:* In February, seven task forces on health care costs were set up by the minister of national health and welfare. Three nurses were among the 40 members appointed to these task forces. *However, none of the chairmen and co-chairmen are nurses. All are doctors or hospital administrators.*

• *Item:* To commemorate the 14th Quadrennial Congress of the International Council of Nurses in Montreal this June – the first time since 1929 that this body, representing the largest group of health workers in the world, will hold its meeting in Canada – the Canadian Nurses' Association asked the postmaster general to issue a special stamp on nursing. After repeated requests the postmaster general advised CNA that a special stamp would, indeed, be released: *it will have Dr. William Osler's picture on it.*

• *Item:* In briefs presented to the federal government in February 1968 and January 1969, CNA documented the need for 2.2 million dollars for nursing education and research. No positive action has been taken. *Yet eight months after CNA's initial hearing, the minister of health found $200,000 for the 45 members of Canada's national hockey team to improve their game in the last half of the 1968-69 season.*[1]

What do these items indicate? One thing: the nursing profession does not have a significant image in the eyes of the federal government.

How important is it for the nursing profession to become "significant" to government? Extremely important. We contend that the public is ill-served when the largest health profession in the country, whose members have considerable expertise in giving and planning patient care, is virtually ignored by government when it is planning, enacting, and implementing health legislation.

Some success in the past

The Canadian Nurses' Association, as spokesman for its 80,000 members at the national level, uses various means to keep the federal government informed of its objectives, policies, and activities. In addition, the association recognizes its role in attempting to influence government on matters that concern nurses, nursing, and health.

In the past, CNA has communicated its views to government in several ways: 1. through meetings with ministers and other government personnel; 2. through the submission of briefs; and 3. through its information services. This lobbying – and, whether we like it or not, it *is* lobbying – has generally been of an informal nature. It has met with success in certain areas and failure in others.

One instance of CNA's success in lobbying was in 1966, when the executive director met with the associate minister of national defence to interpret the association's views about the policy that withheld commissions from male nurses in the Armed Forces. A year and one-half after this meeting, the first male nurse received his commission.

There are several reasons for the success of this lobbying: 1. *Persistence:* although previous efforts to have male nurses commissioned as officers had failed, CNA, prompted by the Registered Nurses' Association of Ontario, continued to press for change. 2. *Unity:* the demand for change was backed by a determined membership of over 74,000 nurses at a CNA biennial meeting in 1966. 3. *Personal approach:* CNA's argument was presented by the executive director in a personal interview with the associate minister. 4. *Timing:* there was a shortage of nurses in the 1960s, and probably a more tolerant attitude toward men in nursing.

CNA has not been as successful in convincing the government of the profession's needs for increased federal funds for nursing education and research. And, despite its efforts, it has had only moderate success in making the profession "significant" in the eyes of government.

Full-time lobbyist needed

CNA's methods of lobbying are no longer good enough to present the association's views to a government whose involvement in health and welfare is increasing yearly by leaps and bounds. The association now needs a full-time lobbyist on staff to maintain a constant, continuous liaison with government.

A lobbyist, or a "CNA government relations representative," would keep the association informed of pending legislation and government policies, and would inform the government of CNA's views and objectives; in addition, the lobbyist would work closely with the association's elected officers, committees, and staff in determining the issues that require action and the strategy needed.

There are two reasons why CNA's lobbyist should be a nurse on staff, rather than a lawyer or public relations person from an outside agency: 1. A nurse-lobbyist would be accepted more readily than a professional lobbyist by government personnel. 2. An outside agency usually has several clients to satisfy and could not always devote enough concerted effort to CNA interests. Also, conflicts of interest among the various clients of the same agency could arise and might be resolved to the disadvantage of CNA.[2]

Strategy

The CNA government relations representative would undoubtedly develop her own tactics or approach. However, certain basic ingredients are essential for effective lobbying.

First, where there is unity there is strength. If nurses are speaking as members of CNA, they should support its representations to government, which are based on decisions made by the elected delegates at each CNA biennial meeting.

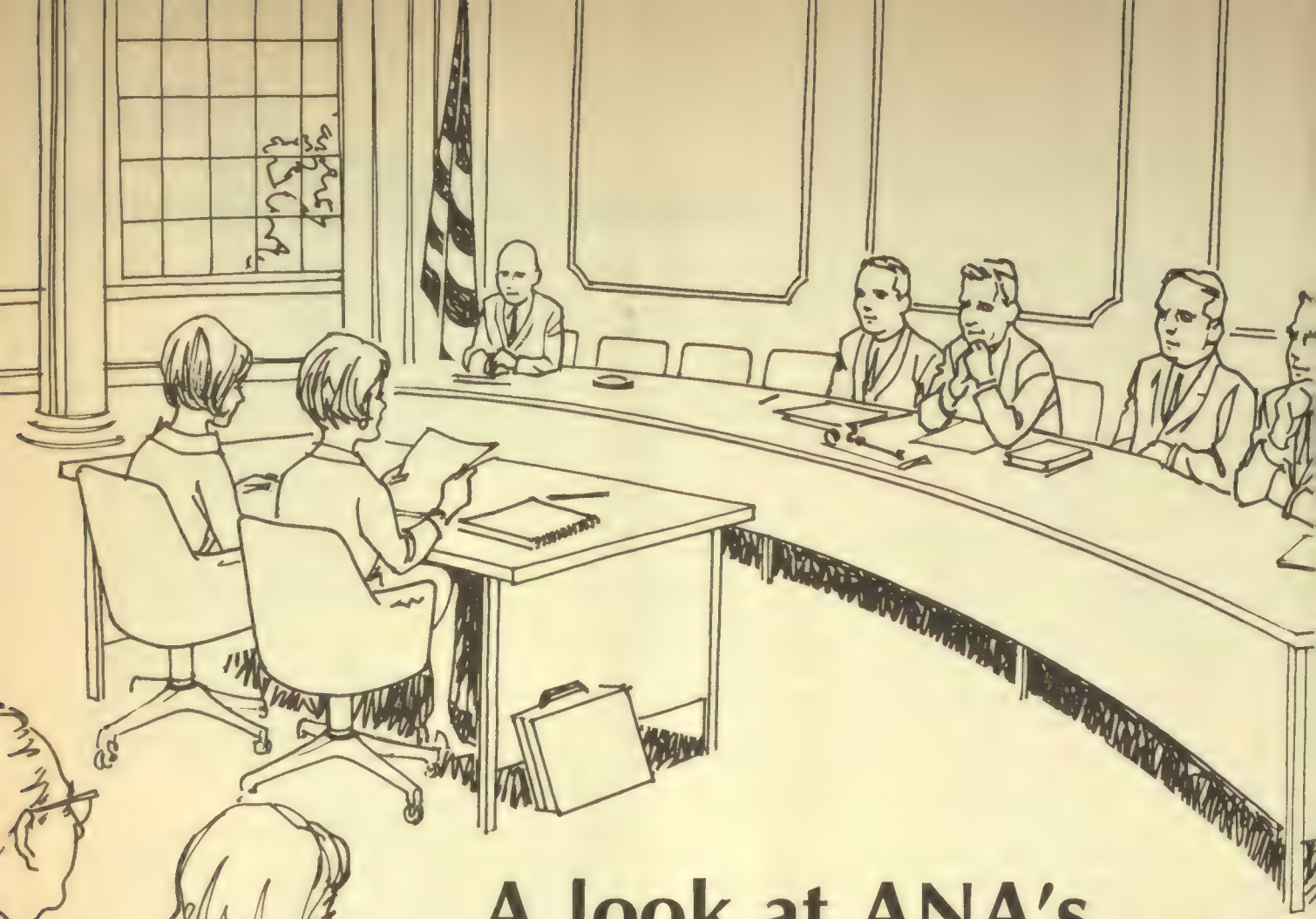
Second, both the elected and employed personnel of government should be kept apprised of CNA's views. It is no secret that senior civil servants are influential in the decision-making process.

Finally, opposition parties should also be kept informed of CNA's views, and should be given copies of the association's statements or briefs to government. As Mrs. Grace MacInnis, M.P., told us, "The government's backbenchers will certainly not oppose government legislation; the opposition members, on the other hand, are under no such inhibitions."* **V.A.L.**

References

1. Good, Shirley R. Too little, for too long, from the federal government. *Canad. Nurs.* 65:5:29.
2. Hutchison, G. Scott. Reactions to the "latent lobby." *Harv. Bus. Rev.* 45:167 July/Aug. 1967.

*The editor expresses her appreciation to Mrs. Grace MacInnis (NDP) Vancouver-Kingsway, The Honorable Waldo Monteith (PC) Perth, and Dr. William Wigle, President, Pharmaceutical Manufacturers Association of Canada, for their helpful comments concerning lobbying. □



A look at ANA's legislative program

Increasingly, the goals of national associations — including the Canadian Nurses' Association — are intertwined with federal government legislation. To find out how nurses in the United States keep government informed and influence legislation at the federal government level, the editor of The Canadian Nurse interviewed staff in the New York and Washington D.C. offices of the American Nurses' Association, and attended a House of Representatives health committee meeting, where ANA presented testimony.

V.A. Lindabury

It was 12:30 p.m., and all seats but one were empty behind the large, semicircular table at the front of the committee room in the U.S. House of Representatives building. Seven of the eight congressmen on the health committee had left shortly before, presumably to attend a general session in the House.

Only a handful of journalists, lobbyists, and observers remained as two individuals presented their organization's testimony before the lone committee member, who had moved into the chairman's seat.

A few minutes later, the acting chairman banged the gavel and declared the session adjourned until 2:00 p.m. There was a groan from the second row, where I

The author expresses her appreciation to the staff of the American Nurses' Association, who so willingly answered her many questions about ANA and its legislative program, and to the Librarian at the Canadian Nurses' Association, for her valuable assistance and unending patience.

sat with Julia Thompson, director of the American Nurses' Association's Washington Office, and Jean MacVicar, chairman of ANA's committee on legislation who was slated to present testimony that morning.

"Is something wrong? Can't the nurses return this afternoon? " the chairman asked with some concern.

"We'll be here, Mr. Chairman," Miss Thompson replied politely and firmly.

And at 2:00 p.m. on March 27, Mrs. MacVicar, with Miss Thompson beside her, faced a committee of five and presented ANA's views on the two hospital and medical construction bills being scrutinized by the health committee.

The American Nurses' Association's efforts to influence legislation at the federal government level date back to 1901, when it was instrumental in having a bill enacted to create the "Army Nurse Corps, Female."[1] Since then, ANA, as spokesman for its 204,704 members, has taken a stand on many issues that affect nurses, nursing, and health, from social security to gun control.

I asked Judith Whitaker, executive director of ANA, and Margaret Carroll, deputy executive director, how ANA's legislative program had evolved.

They explained that the problems of state nurses' associations to obtain mandatory licensing laws had catapulted ANA into action in the early 1900s. In 1914, the association created a central bureau of legislation and information to facilitate the legislative programs of the state nurses' associations.[2] Later, two committees on legislation were set up by ANA, one to deal with legislation that came under state jurisdiction, the other, with legislation that came under federal jurisdiction.

"A good part of this first committee's time was spent developing tools and techniques for influencing state governments," Mrs. Carroll said, "whereas the committee on federal legislation was primarily concerned with federal aid to education, although it became involved with other issues. For example," she continued, "in the 1930s and 1940s ANA was successful in getting professional classification for nurses in the civil service, supported the setting up of a national department of health and welfare, and pushed for a food and drug act."

Eventually the two committees were dissolved and replaced by one, called the ANA committee on legislation. This committee, composed of nurses appointed by the ANA board of directors, was originally set up as a policy-making body for the association's total legislative needs.

According to Mrs. Whitaker and Mrs. Carroll, the role of this committee has changed somewhat since ANA set up its commissions on service, education, and economic and general welfare in 1966. (The commissions are similar to the Canadian Nurses' Association's three standing committees.) The business of formulating legislative policies in these areas is now the prerogative of the commissions. The policies they enunciate are, of course, within the framework of ANA's platform as decided biennially by the house of delegates, the voting body of the association.

"However," Mrs. Carroll said, "it appears that the committee on legislation is still needed, mainly to pull together the total legislative concerns of the association and to arrive at priorities in terms of what is feasible in the present political climate and in terms of the association's resources. "Actually," she continued, "this committee is becoming less of a policy-forming committee and more of the 'committee of politicians.' "

Lobbyist appointed

Mrs. Whitaker said that much of ANA's lobbying efforts in the early days was carried on by nurses employed by the federal government – "quite an illegal way of lobbying," she added with a chuckle. "Later, the chairman of the original committee on federal legislation, who was also executive director of the District of Columbia's nurses' association, served in a voluntary capacity as lobbyist, testified at hearings, and occasionally called on congressmen."

Although this informal type of lobbying had been fairly effective in the past, it was obvious to ANA that more forceful and concentrated efforts would be needed in future as the federal government was becoming increasingly involved with health legislation. Two issues, in particular, were of concern to ANA and required immediate attention: the need for more federal aid for nursing education; and the need to press for changes in the existing labor legislation (Taft-Hartley Act, 1947), which excluded non-profit hospitals from collective bargaining.

"We realized that if we hoped to influence government, we needed someone on the scene who could keep a constant watch on legislation that was before Congress," Mrs. Whitaker said. "We needed someone who would establish relationships with the congressmen, their administrative staffs, and the federal agencies that are involved in developing and implementing legislation for both the legislative and executive branches of government."

In 1951, ANA appointed its first full-time lobbyist – Julia Thompson, a registered nurse who had been a member of the committee on legislation – to its staff as "Washington representative." Today, the association's department of government relations has five full-time staff members, two at ANA's headquarters in New York City, and three in Washington.

"In the future," Mrs. Whitaker said, "we plan to have enough staff in the Washington office to deal with legislation that affects the major areas of service and practice, education, and economic and general welfare. This would be in addition to the director in Washington, whose main job would be to coordinate activities."

Action program at federal level

Helen Connors, director of ANA's government relations department, explained that the association's legislative program is one of action at the national level and consultation at the state level. "Nationally," she said, "we try to keep the federal government and the bureaucracy informed about ANA's stand on health matters, and attempt to have certain legislation enacted or amended. We work closely with the state nurses' associations, as it is most important that they be kept informed of what we are doing. Furthermore," she added, "we depend on the state nurses' associations and nurses within each state to support our efforts by writing to their congressmen on various issues."

I asked Miss Connors if ANA ever found it necessary to obtain the state nurses' associations' approval before taking a stand on a specific issue.

She said that a referendum vote of approval is seldom necessary, mainly because the association has become quite sophisticated in identifying the legislation likely to come before Congress, and has been able to get a broad platform from its house of delegates every two years to cover most exigencies. "Occasionally," she added, "the ANA board of directors will refer a recommendation of the committee on legislation about a controversial issue to the House of Delegates for approval.

As an example of controversial legislation, Miss Connors cited the medicare bill, introduced in 1958, which recommended health care coverage for persons over 65 years. "Presumably," she said, "ANA could have supported this bill without referring it to the House of Delegates for approval, because of the

association's previous endorsement of social security improvements. However, we recognized that there was not unanimity on this bill – in fact, one state nurses' association later went to Congress and testified in opposition to ANA's position – so the ANA board of directors referred the issue to the association's House of Delegates, in which every state in the union is represented. At the next ANA biennial meeting, the House of Delegates approved the principle of supporting the medicare bill," Miss Connors added, "and our department was then charged with working out the strategy for presenting the association's views to Congress."

Miss Connors admitted that ANA had "gone out on a limb" last summer, when it supported former U.S. President Johnson's bill to tighten gun legislation. "This proved to be a very controversial issue," she said, "and we had a lot of opposition from our members. We didn't refer this to the state nurses' associations for approval, mainly because we felt we had a right to support meaningful gun legislation, as it is the nurse's role to help preserve life.

"As a citizen in a democratic country, any nurse has the right to disagree with the association on any issue," Miss Connors said. "However, we point out to our members that if they are speaking for the association, they should present the association's position, regardless of their own feelings. Otherwise," she added, "we merely confuse the legislators and get nowhere."

Miss Connors feels strongly that nurses should present their viewpoints to government without making compromises first. "Go to the legislators with your pure, unadulterated demands," she said firmly. "Let the *legislators,* who are faced with many pressures, make the compromises."

How ANA lobbies

"Be firm, friendly, and feminine – that's my motto," Julia Thompson said with a conspiring wink as we sat in her Washington office the day before she and Mrs. MacVicar presented ANA's statement to the congressional health committee. And judging by ANA's successes in lobbying since Miss Thompson was appointed in 1951, this 3F strategy seems to work.

According to Miss Thompson, ANA has a good reputation with Congress, mainly because it supports issues that are socially oriented and concerned with people, rather than issues that benefit only the profession. She said that ANA has a somewhat different approach than other organizations to lobbying in that the Washington staff rarely entertain congressmen or senators, mainly because it is unnecessary and they do not want to be accused of 'buying support.'

Miss Thompson explained that ANA's lobbying activities are mostly directed to three areas within government: 1. the committees of the Senate and House of Representatives, where most of the work of Congress is carried on; 2. the executive branch, including the cabinet members and their agencies; and 3. the bureaucracy.

"We have several ways to present our views to personnel in these three areas," Miss Thompson explained. "First, we can appear in person and testify at a committee hearing. Second, we may decide not to appear in person before a committee, but to file a statement with the committee chairman. Third, we may visit a committee member or a civil servant in his office, and explain our point of view directly. Fourth – and this is a very important part of our program – we often ask state nurses' associations and their members to write to the senator or representative from their state or district."

I asked Miss Thompson about the effectiveness of testimony presented at committee hearings. Did an organization's testimony really influence legislators?

She said yes, she believed it did, even though some cynics maintain that most committees have a predetermined notion of what they are going to do. "We feel we have an opportunity to become known," Miss Thompson said, "and to present our point of view, which is then published for public information. "After all," she added, "it is just as important to get this information out for public consumption as it is to get the congressmen to pay attention to it."

What about letters to congressmen from their constituents? Are these effective in convincing them that ANA's demands are worthy of consideration?

"It depends on the letter," Miss Thompson answered. "If it's a form letter or postcard, it's not too meaningful.

"When we decide that an issue requires support from ANA members, we send a memo to the state nurses' association, school of nursing, or individual nurse requesting that a letter be sent to the congressman involved who represents the state or area. We ask the person writing the letter to be specific in outlining the reasons *why* the enactment or amendment of the legislation under study is important to the nurses in that area. We find that congressmen do pay attention to this kind of letter," she said.

Breakthrough on education

ANA's most successful instance of lobbying, according to all the ANA staff I interviewed, was in getting legislation enacted for federal aid to nursing education. "We had been trying for years to secure federal assistance for graduate education," Miss Thompson said, "and we were finally successful in 1956."

Earlier, when I had spoken to Mrs. Whitaker and Mrs. Carroll in New York, they had pointed out that the passing of this legislation represented the first *real* breakthrough in federal assistance. This success, they said, had been due, in no small part, to the concerted and constant attention of their Washington representative, Miss Thompson. (A comparison of the U.S. federal government's annual appropriations to nursing education with the Canadian federal government's appropriations can be found in "Too little, for too long, from the federal government," by Dr. Shirley R. Good, in the May 1969 issue of *The Canadian Nurse).*

Miss Thompson hastened to point out that not all of ANA's lobbying efforts have been successful. To date, she admitted, ANA has been unable to get the government to amend a clause in the national labor relations act that excludes non-profit hospitals from collective bargaining.

"Each year we ask a congressman to introduce an amendment to the Taft-Hartley Act to remove that clause," she said. "We can always find someone to introduce this bill, but then it just dies in committee. We've been told that it's useless, until the two major forces – labor and management – decide they want the labor relations act opened for amendments.

"We've been trying to get this changed since 1937, and still no luck," Miss Thompson said ruefully. "But everything takes time," she added with a twinkle, "and we'll keep plugging away."

This writer has no doubt that the *4F* strategy – firm, friendly, and feminine, with a large dash of *fortitude* – will ultimately take Taft-Hartley apart successfully.

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Private duty — private choice

To find out why nurses are attracted to private duty nursing and some of the pleasures and problems inherent in this type of nursing, The Canadian Nurse asked the author, a freelance writer and researcher, to interview several private duty nurses whose home base is Toronto.

Carlotta Hacker, M.A.

Why do registered nurses choose to become private duty nurses, rather than staff nurses in a hospital? The income is uncertain and many young nurses find they have to do a high proportion of night duty to bring in a reasonable salary. In the winter months, work is not always available.

Private duty nurses receive no pay during holidays or times of sickness, and no insurance schemes are provided for them: if they wish to have a pension plan, medical insurance, or malpractice insurance, they have to organize it themselves — an expensive business, as there is no employer to contribute to the payments. Similarly, if a patient does not pay a bill, it is up to the private duty nurse to pursue the bad debt and, when necessary, hire a lawyer. They are very much out on their own.

Yet each year a small proportion of nurses continues to sign on at the registries.

"I like it for the freedom," says one.

"I like it because I can work when I want, have what days off I want, and have what holidays I want," was another opinion.

"It's far more interesting than being a staff nurse. More interesting and more stimulating."

This last explanation has been expressed in a variety of ways, but it was the chief reason given by private duty nurses at Toronto General Hospital for their attraction toward their work. The independence of it appeals to them too, because they are independent people by nature. You have to have a certain self-confidence and self-sufficiency to cope with the insecurities inherent in "specialing" — but the basic appeal is the work itself.

"I used to be on staff in the respiratory unit," says Elizabeth Sanmiya, who has been doing private duty since 1965. "I think that's the main reason why I started 'specialing': because I liked working there, and I liked the idea of going to all the different parts of the hospital and looking after seriously ill patients."

Miss Sanmiya prefers the night shift because it fits in well with her evening classes. Since starting private duty she has taken Japanese and Grade 13 French, and she is now enrolled in a course in massaging. Continual night duty has made this possible.

Beverly Bell, who has done private duty for a year now, also started on staff. She began private duty as a temporary measure after returning from a year in England, and she liked it so well, particularly the intensive care, that she stayed at it.

"I think I have learned as much during this last year of 'specialing' as I did in my three years of training," she says. "You get such a variety of cases."

Like most of the private duty nurses who were interviewed at Toronto General, both girls feel that they have gained more experience and kept more up-to-date than they would have done in a staff position. This seems to be one of the strong attractions to private duty.

And the general opinion seems to be that the pay is approximately equivalent to that of a staff nurse, although income is certainly one of the insecurities. You may be lucky and have the chance of earning a high salary for a short period, but there are also the lean times to take into account.

Some of the private duty nurses have experienced antagonism from regular staff because they are thought to earn more for equal work. Certainly a special's pay packet for a week's work is fatter, but tax has not been deducted at source, and she receives no pay packet at all during holidays and sickness, or when she can't get work.

Antagonism has also occasionally been experienced when the staff are busy and the private duty nurses are not.

"But the patient is paying us," said one special. "So he is entitled to our full care and attention. That's why we're there."

The author, an English and History graduate of St. Andrews University in Scotland, is a frequent contributor to *The Canadian Nurse*. Her book . . . *And Christmas Day on Easter Island* was recently published by Michael Joseph Ltd. of London, England.

The author of the article and the editor of *The Canadian Nurse* express their sincere appreciation to the staff at Toronto General Hospital and to the director of the Central Registry of Nurses in Toronto for their valuable assistance.



Elizabeth Sanmiya and Beverly Bell relax with the author over coffee before going on duty.

"Envy enters the picture quite a lot," was another opinion. "Some members of staff resent our freedom because we aren't part of the hierarchy."

But on the whole the private duty nurses can see few disadvantages in their work. There are not, by any means, always personality difficulties with staff. And many obstacles, which the less intrepid might consider to be disadvantages, are brushed aside with slight surprise that they could present any problem.

No . . . there's nothing terrifying about moving into a new ward or unit, or even a different hospital. It's interesting to meet new people and tackle a new job . . . Income tax? That's not much of a problem. It may be a bit difficult to work out the first year, but you learn by experience and organize it properly from then on.

Even non-payment by a patient gives no particular cause for worry. If he doesn't pay his bill (and this is a rare occurrence) then you simply send a reminder and, if necessary, a lawyer's letter. Most private duty nurses present their bills weekly on a long case so that the patient is aware of how much the special care is costing him. Margaret Kellough, also of the Toronto General, makes a habit of doing this.

"Because I know what it costs! " she says. "I've been a patient myself with a special nurse."

Miss Kellough has been in private duty a long time. It appeals to her because, as she says, "I enjoy people," and she feels that private duty gives her the opportunity to nurse her patients single-mindedly. She can get to know them, and give them the encouragement and personal attention that a staff nurse seldom has time for. Because of this close contact with the patient, Margaret Kellough prefers private duty to any other form of nursing.

She has had considerable experience in other fields. She gave up private duty in 1939 at the outbreak of war in order to volunteer and, within three days of writing to the Red Cross, found herself in the army. She worked in England during the Battle of Britain, in North Africa with the 15th Canadian General Hospital (a tent hospital: lanterns, flashlights, and outdoor plumbing) and then landed with the troops in Italy where she took charge of a casualty clearing station.

"We were only a few miles from the German lines, with the big guns shooting over us."

Miss Kellough was decorated A.R.R.C. for her African service, and after the war she continued nursing the military for a while at Malton. Then, after running the hospital at Port Hope for six years and taking on a crippled children's camp, she made an attempt to resume private duty. This attempt was soon foiled when a doctor persuaded her to organize and run an eye surgery clinic for him: a fourteen-bed private nursing home. But in 1956 she did at last succeed in returning to private duty.

"A lot of people thought I was very foolish going back to it after all that experience," she says. "But, you see, I really enjoy private duty nursing."

Miss Kellough considers that it gives her far more job satisfaction than she is likely to find in a staff position, because each of her assignments is an entity that she can give all her attention to and follow through. And she feels strongly that personal attention by a special nurse can hasten recovery.

"I truly believe that people get out of hospital faster," she says. "I don't spoil patients, but I can give them the confidence to do the things they should do. Like early ambulation. If you're there with them, you can suggest it to them gradually. You can take a lot of worrying from them too, so that they relax. And you can listen to their complaints and generally make things run smoothly."

And things do run smoothly, with both staff and patients, when she is on duty.

When it is possible, Miss Kellough gets her patient into a wheelchair and does a tour of the hospital, showing him the swimming pool, the occupational therapy, the physiotherapy, the carpenter's shop and the ceramics shop.

"It makes it more interesting for the patients," she says. "I don't want them lying there in bed just thinking of their operations."

Not surprisingly, many patients who have been under Miss Kellough's care ask for her as their nurse if they have to return to hospital for another operation.



Elizabeth Sanmiya, a private duty nurse since 1965, prefers the night shift since it allows her to take evening classes.



Beverly Bell began private duty as a temporary measure after returning from a year in England, and liked it so well that she stayed at it.

But she will not always guarantee to nurse them because she does not like to start a new assignment, however attractive, if it means leaving the previous patient while he still needs a special nurse.

Her patients vary widely. Obstetrics and intensive care units are the only areas where she prefers not to work now, although of course she had experience of intensive care when it was being given in the general wards. She enjoys the diversity and finds it far more interesting than working on the floors, where nurses are more likely to care for many patients who have had similar operations.

But she does consider the lack of security a strong disadvantage. She has taken out her own pension and sickness policies. She feels this is a sensible move.

"Because you don't make money at private duty," she says.

She considers that she has to work longer hours to earn the equivalent of a staff nurse's salary.

Margaret Kellough generally has to wait a few days between finishing one case and starting another, partly because she only takes the most popular eight to four shift now. She likes to live a normal life and see her friends in the evenings, and it is impossible to do so if she is working at night. As it is, a regular routine is difficult for her, because a patient may require care longer than anticipated — perhaps for 10 or 14 days at a stretch — which may mean cancelling a weekend in the country or being on duty at Christmas.

Miss Kellough does not insist on a five-day week. Her own life is fitted round her patients' requirements, rather than the other way round. In a long assignment, she will find a reliable deputy to give her a few days' break every week or so, but she sees a shorter case through to the end, without any break, for she considers it upsetting for a patient to have to adapt to a change of nurse.

So, because of her principles, she is not entirely a free agent. However, like all private duty nurses, she has the opportunity to work when she wants to (providing work is available) and she can take the holidays she wants. Eight years ago she was able to attend the International Congress of Nurses in Melbourne and include a holiday in the Far East. The trip lasted nearly two months. Four years later she was able to attend the Congress in Frankfurt.

Such extended holidays would be difficult for a staff nurse. But the ability to take these long vacations is only a pleasant sideline to Margaret Kellough's work. The true reason why she returned to private duty is because of her empathy with people and because of the great satisfaction the work gives her.

She is slightly worried that private duty work may diminish or even cease in the future, not because there will be no need for it, but because she thinks it holds less appeal for younger graduates who like a regular five-day week. However, younger graduates are still recruiting as specials and one of their reasons is the same as Miss Kellough's: job satisfaction. But the job tends to be different.

Valerie Braden, who graduated in 1961, has done most of her special duty in intensive care units. She finds this stimulating, challenging, and extremely interesting. Like Miss Kellough, she has an independent nature and, when necessary, has no fear of speaking out. Like Miss Kellough, she is absorbingly interested in her work. But, unlike Miss Kellough, it is the intensive care units that appeal to her, rather than the less dramatic forms of nursing.

Her first taste of intensive care was at the Toronto General Hospital where she worked on the respiratory unit for several months.

"It was very good experience," she says, "because I completely overcame my fears of respirators and acutely ill people."

Then the Toronto General set up a unit for coronary patients and applied to the registry for graduate nurses to help staff it. So Miss Braden did special work there. But the private duty she most enjoyed was the 10 months she worked on the intensive care unit at The Hospital for Sick Children in Toronto.

"There was a wonderful sense of camaraderie," she says. "Everyone pitched in to help everyone else. It was hard work, and we were doing quite irregular shifts, but it was fantastically stimulating. And it was a good learning experience too, because nothing was ever static. We had



Private nursing appeals to Margaret Kellough because she finds she has time to give her patients the personal attention and encouragement they need.



Valerie Braden, a 1961 graduate, prefers private nursing in the intensive care units. She is seen here (left) with Mrs. E. Tyer, a head nurse at the Toronto General Hospital.

all the open heart cases, a lot of neurosurgery, and lots of the acutely ill medical cases."

Inevitably, when Miss Braden was working on intensive care, a schedule had to be made out and she kept to it, but generally she can work or take a holiday as she desires. Like so many other specials, she appreciates this aspect of private duty nursing.

In spite of the longish holidays she takes periodically, she considers that, with effort, her income can be as much or even more than that of a staff nurse. Uniforms and transport can be claimed against tax, because she is self-employed. And, although she receives no salary during long vacations, she can work extra hard while saving to go for six weeks to Hawaii, for instance. She can do a spell of night duty, which is easier to come by than the eight to four shift that she usually works. Quite often there has been the opportunity to make extra income by doubling and nursing two hospital patients in the same shift.

"But when I earn more, it's probably because I work more," she says. "I'm sure I work more days per month than the average staff nurse."

She is not particularly concerned about the insecurity of her employment. She sees insecurity as a necessary companion to independence. Maybe there are periods in winter when she would like to be on duty and isn't, but there is often the night shift to fall back on. If this also fails, then she remains on call, fretting slightly, but aware that being out of work is sometimes an unpleasant corollary to the freedom of private duty nursing.

Like Miss Kellough and other special nurses, Valerie Braden enjoys the variety of experience that private duty brings. Like them, she feels that she keeps more up-to-date than a nurse who stays in one area. She is prepared to tackle anything, so even when not working on intensive care she has had a cross-section of interesting patients. However, she has also had a proportion of assignments that have largely been "hand-holding," and she does not enjoy these after the first couple of days: she feels that they are often a waste of the patient's money and her time.

"There's no challenge or stimulus," she says. "I feel I'm not fulfilling my potential."

Recently the Toronto General Hospital has stopped employing special nurses from the registries, and other Ontario hospitals are also having to cut down. This means that private duty work in the province is likely to involve far more "hand-holding" assignments. So Miss Braden is considering some other form of employment. She could, of course, sign on as a member of staff, but she has grown accustomed to her freedom and can't see herself fitting in comfortably with a hospital routine.

"I'm thinking quite seriously of going into public health," she says. "It would mean going back to school, but I could work in the vacations. I'm very interested in organizations like World Health, and would like to be contributing in that area."

So it looks as if private duty may lose Miss Braden – except in the college vacations of the next two or three years. Because of the cuts in hospital charge patients, it has already lost a number of nurses. Some have gone on staff, some have gone on relief nursing. Others have left nursing altogether.

But it also looks as if a proportion of graduate nurses of all age groups will continue to be interested in signing on with the registries for private duty. Their reasons will vary. Some may see it as a convenient temporary job, while others will be drawn to it because of the close relationship it offers with the patient. Some may find it stimulating and absorbing, while some may use it only as a useful and uninvolved form of income.

But most graduates who sign on with a registry in a regular manner are private duty nurses because they find satisfaction in this form of work. Although private duty nursing has decreased considerably over the last 50 years – partly because there is so little graduate nursing in the home nowadays – it is likely to continue to some extent, since there will always be patients willing to pay for the extra care.

And it looks as if there will continue to be nurses willing to give this type of care. □

Unit assignment — a new concept

A different staffing pattern could create greater nurse satisfaction and improve patient care.

Kay Sjoberg, B.Sc.N.

The University Hospital in Saskatoon has implemented a new staffing system on its 47-bed research ward. This ward is organized into six units of care — one three-bed intense care unit, two five-bed above average care units, and three average care units.

A unit is defined as the number of patients that can be effectively cared for by a registered nurse who is given adequate nursing assistance and supply services. The size and staffing of each unit depends on the care category of the patients assigned to the unit. The ward consists of the number of properly staffed units that can be managed by a head nurse who is given adequate clerical and service coordinating support.

Each unit has a mobile station, located in close proximity to the patients, which houses the charts, doctors' orders, medications, sterile and unsterile supplies, stationery, and a telephone intercommunication system. The unit station is thus the center for communications and supply delivery.

Unit assignment

The new staffing pattern, known as the unit assignment system, developed from a recommendation of the first phase of a nursing study completed at the University of Saskatchewan in 1967. The second phase of this study was designed to implement and evaluate this staffing pattern and to conduct a feasibility study on measurement of the quality of patient care.

On admission, patients are categorized according to their need for care and are assigned to the appropriate unit — intense care, above average, average, or minimal care. This four-level patient classification system was also developed in the first phase of the study.

In May 1968 the system was compared with the patient classification model developed by Dr. Asa MacDonell at Deer Lodge Hospital, Winnipeg. Simultaneously, both systems were compared with the head nurses' independent evaluation of the level of care required by the patient. This further study assured the research team that the phase I categorization system is a valid tool to classify patients quickly into levels of care depending on the amount of nursing care they require.

Since the prime objective of the unit assignment system is to deliver personalized patient care effectively, the head nurse assesses daily all patients on the ward. If the patient's care category has changed and is expected to remain stable for approximately two days, the head nurse initiates the patient's transfer to the unit that is staffed and equipped to meet his needs. Patients are moved within the ward approximately twice during their hospital stay.

Mrs. Sjoberg, a graduate of the University of Saskatchewan School of Nursing, is currently Project Leader of the Nursing Study, University Hospital, Saskatoon, Saskatchewan.

The head nurses' role

What is unique about this system? The head nurse on the ward remains responsible for providing nursing service, but she delegates the administration of each of the units to her unit nurses. She also delegates clerical functions, the ordering of supplies, and service secural to her service coordinator. This gives the head nurse time to apply her knowledge, experience, and clinical competence directly to patient care.

The head nurse is the key person in creating a therapeutic environment for patient care. She guides, supervises and assists her unit nurses to meet the goals of personalized patient care; supervises patient care; teaches patients and nurses; orientates new nursing staff; evaluates staff performance; and conducts the multi-disciplinary patient care conference.

Staffing patterns

The unit assignment system permits a certain degree of flexibility in staffing. Each unit nurse is a registered nurse responsible for total patient care. She works with her assistant, directing and supervising patient care. There is no formal assignment for a unit assistant.

Unit nurses and unit assistants are assigned by the head nurse daily to a unit; continuity of assignment is promoted

through a weekly assignment plan. The size of the unit varies, depending on the numbers and needs of the patients. The key is to establish a unit of appropriate size to permit the unit nurse to supervise patients' care, work with her assistants, and be in control of the situation.

An evening nurse in the above average care unit assumes responsibility for two day-shift units; a night nurse in the average care unit assumes responsibility for as many as three day-shift units. The number and level of staff assigned to the intense care unit remains constant. Every attempt is made to match the nursing staff to meet the patients' needs and to equalize the nurses' assignments from day to day.

The unit assignment system uses exactly the same budgeted staff as the team method of assignment. Floats are still required, although less frequently.

Nursing assistants and orderlies may assume the role of unit assistant. They expect direction, supervision, guidance, and teaching from their unit nurse. They work with her and are never in complete charge of any patient's care. Orderlies find their new role rewarding, although they are still responsible for performing male procedures in other units.

Student nurses enjoy their assignment to the research ward for senior surgical experience. They function as observers and unit assistants. The role model set by the unit nurse should enrich the students' experience. We have found it wise to limit the number of observers. For this reason, only two students are assigned for experience on each day shift.

Communication

Doctors and all other members of the health team communicate directly with the unit nurse who has up-to-date information on each patient's condition and progress. The patient's treatment plan, needs, reactions, and preparation for discharge may be discussed. The unit nurse plans with the other health disciplines to schedule the patient's activities, such as physiotherapy, occupational therapy, social service, x-ray, and speech therapy. This direct communication helps maintain continuity of care.

All departments in the hospital cooperate to allow the patients to rest from 1:00 to 2:00 p.m. daily. During this period, the nursing staff discuss plans for patient care, participate in patient care conferences, and revise charts or kardex as necessary.

Two formal patient care conferences are held each week, and are attended by a doctor and other members of the health team. These conferences are conducted by nurses and center on the patient's illness, progress, needs, nursing intervention, teaching, and preparation for discharge.

When shifts change, each day unit nurse reports verbally to the evening unit nurse and her unit assistant. This method of reporting encourages two-way discussion of the patient's progress, treatment, and nursing care. Continuity of care is aided and some communication problems are resolved because each unit nurse is expected to relay information from the doctor, social worker, and physiotherapist.

Service staff

Our service staff includes a coordinator, clerks and aides. The service coordinator provides the continuing services required to meet the environmental needs of the patients. In securing supplies, she works closely with many departments: laundry, central supply, oxygen therapy, pharmacy, dietary, housekeeping, maintenance, admitting, and purchasing. She supervises and maintains all clerical and receptionist functions of the ward and assigns and supervises the aides' duties. The service clerks take care of the clerical needs of the units and the ward.

The service coordinator meets with the housekeeping team leader to plan for the housekeeping of the patients' rooms. This is done daily when the head nurse completes the patient categorization.

Supply standards have been determined for each portable unit station. These standards are replaced each shift by the service staff. Aides take supplies to the units when required. Other responsibilities are included in a detailed job description. The service staff play a vital role in the unit assignment system of staffing and an indirect though important role in patient care.

Conclusion

The unit assignment system of staffing progressed through the cooperative support of hospital administration, medical staff, nursing staff, and the supporting hospital service departments. Its effectiveness can be partly measured by staff response.

Nurses on the unit have found that communications have improved among members of the health team. Also, because nurses spend less time performing non-nursing activities, they have found that they know their patients as people and can provide more individual care.

There is time, too, for professional growth and learning. Nurses are encouraged to experiment with their own ideas to improve patient care. They use their professional talents and are given recognition by both staff and patients. As a result, organization improves and time is used more effectively. These comments came from nurses involved in the unit care system.

In the coming months the unit assignment system of staffing will be evaluated by the research team, using activity studies, gross quality of patient care studies, cost studies, and a staff satisfaction questionnaire. The nursing service research study will assess its overall effect.

Does the unit assignment system lead to more effective personalized patient care with greater job satisfaction for nurses without increasing costs? We are still looking for the answer.

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Top right: Above Average Care Unit. Because the nurse is serviced close to the patient, her main focus can remain on the patient.

Middle: service staff – coordinator, clerk, and aide.

Bottom right: Supply section separate from desk. Supply cart is easily wheeled from patient to patient.

Top left: Stationery file.

Bottom left: Medication and sterile supply section of unit station.











Insulin injection — a new technique

Description of a method that the author claims is easier, more effective, and painless.

Peter St. James

In working with diabetics for over 10 years, I became concerned about the method used to inject insulin by the patients themselves, nurses, medical staff, and anyone else responsible for the injection, such as parents of diabetic children. The injection seemed to be one of the greatest obstacles to both the new and the "experienced" diabetic.

I set out to develop a method that would be painless, effective, easy to perform, and that might eliminate the disfiguring hollows on the diabetic's body. I have found great success with this method, both in its ease of technique and in the resulting disappearance of the insulin atrophy and hypertrophy marks, which were very evident in some cases.

I have used this method with both male and female patients, who range in age from 8 to 41 years. Their dosages range from 6 to 80 units in each injection.

Rotate area

Insulin should always be injected to reach the loose space under the skin between the fat and the underlying muscle. If the dose is injected too close to the surface, it enters the fat or the skin and causes a painful stretching and swelling.

The author is indebted to Pam Morgan for her invaluable assistance and to all the other diabetic patients who have tried and found success with this method.

The site of injection must be rotated through as many areas as possible, changing the location each day by at least two inches. If given in the same area, the tissue becomes hard, lumpy, and discolored and the insulin may not be properly absorbed.

Occasionally there will be a little bleeding at the point where the needle is withdrawn. This means that a small blood vessel close to the surface has been penetrated; this is harmless, and no cause for alarm.

The actual pain of an injection is caused by passing the needle through the nerve endings of the dermis layer of the skin. If the needle is inserted quickly, the pain is minimal and of short duration; if it is inserted slowly, the pain is drawn out. By actually "darting" the needle into the skin, there is no pain at all.

It is common to pinch the skin before inserting the needle, but there is no need to do this as it only brings together more and more nerve endings. If you pass a needle through this gathering of nerve endings, there is sure to be some discomfort.

Technique

- Wipe the site of injection with an alcohol swab.
- *Dart* the needle *straight* into the skin to the hilt of the needle.
- Gently pinch a large fold of skin and underlying fat. This brings the point of

the needle into the loose space under the skin.

- Slide the plunger fully down to inject the insulin.
- Withdraw the needle.
- Apply slight pressure with the alcohol swab over the area for a minute or two.

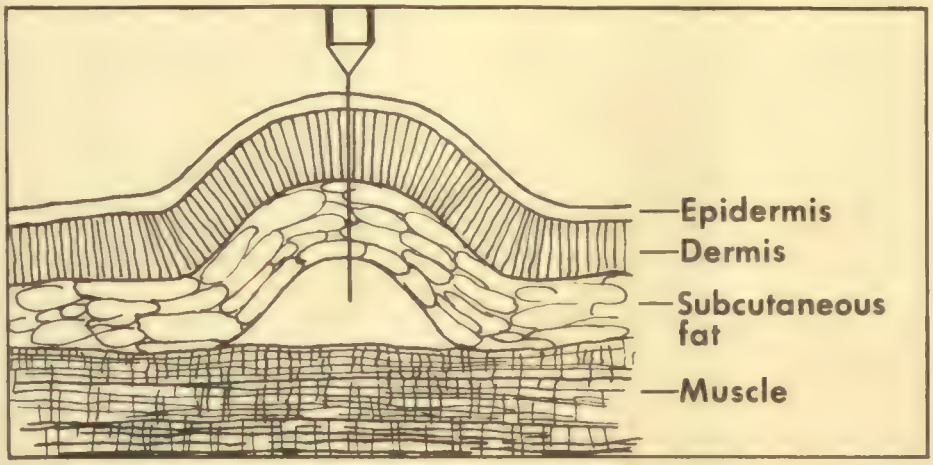
The second step must be done quickly, which may require practice at first. With this method there should never be any discomfort from the needle, nor should there ever be any mark or hollow in the skin — provided the site is changed every day. Do not use the same site more than once every three weeks. Rotate the site daily.

The object is to get the insulin into the space between the skin proper and the underlying muscle tissue. By inserting the needle perpendicular to the skin, the point of the needle penetrates deeply enough to pass through all the layers of skin.

I have found that when the skin is pinched and the point of the needle is about to pass through the first layer of skin, it folds in the center, making the injection difficult to perform. This is particularly evident when the patient has tough skin. By not pinching the skin, but allowing it to remain flat against the muscle, the penetration of the needle becomes a much simpler task. Once the needle has penetrated all layers, the skin may be lifted up to assure that the point of the needle is in the proper space and not resting in muscle tissue.

Teaching technique

In teaching my diabetic patients, I have them first push down with the alcohol swab; this leaves a small white spot that disappears in a matter of seconds. The idea is to have them insert the needle before the white spot disappears, which is just a method of getting them to overcome their hesitation and to learn to insert the needle quickly.



I explain that it is the nerve endings that cause the discomfort and that pinching the skin only brings more nerve endings together. I tell them that the nerve endings are separated when we push down with the alcohol swab. In reality it is the speed with which the needle is inserted that minimizes the discomfort.

I have found this method particularly rewarding when teaching children the technique. After a few successful attempts, the diabetic convinces himself that insulin injection is painless and easy to perform by himself.

With this method there is no need to aspirate the syringe, as the tip of the needle is in a space under the skin and cannot be in a blood vessel. No matter how many thousand times a diabetic is told to aspirate the syringe, he always seems to forget. In using this method, he can "forget" and not worry about it. □

Mr. St. James, a graduate of Woodstock General Hospital, is presently employed at the Clarke Institute of Psychiatry in Toronto. He is an active member of the Canadian Diabetic Association, and has written several articles on diabetes.

Lady Mary Wortley Montagu - eighteenth century crusader

The story of one woman's crusade to control smallpox.

Dorothy Metie Grant

Years ago, when I was a student nurse, I was anything but impressed with my classes on the lives of the early pioneers of preventive medicine. To me, men like Pasteur and Jenner were only paper-thin characters imprisoned in the dull, ponderous chronicles of nursing textbooks.

Looking back, it seems to me that the problem rested with the writers: few had put into words the incredible drama underlying the early struggles of countless men and women in their fight to control infectious diseases.

Recently I discovered one of these fascinating stories as I browsed through several history books. My detective instincts were aroused when a woman's name – Lady Mary Wortley Montagu – kept appearing in connection with smallpox control. Further reading provided me with a picture of a truly outstanding character.

Lady Mary, the daughter of an English aristocrat, was one of those rare women whose intelligence and determination make then unique in any era. She was destined to become one of the leading social satirists of her century, and her numerous letters are now considered to be among the best sources of information on English life and politics during the 1700s.

Mrs. Grant, a graduate of Halifax Infirmary School of Nursing, lives in Halifax, Nova Scotia, where she is a freelance writer.

Early in life she experienced the cruel effects of smallpox, first by her mother's death, then by the death of her only brother.

Although smallpox had first shown its lethal disposition in England during the reign of James I,[1] it was a relatively new disease in the early 1700s. But from that period on, it began to rake the country with ruthless vengeance.

Lady Mary contracted smallpox in 1715, three years after she was married, when she was cultivating a prestigious position at the court of George I. Under the care of the royal physicians, she recovered, but was left with deeply pitted skin and the permanent loss of her eyelashes. Her famed beauty had been destroyed by a disease that would take the lives of 60 million people before the century was over.[2]

Lady Mary was an embittered woman during her convalescence, but she was extremely fortunate to have survived an attack of smallpox. All over Europe people were dying from the plague, or were left deformed. Portrait painters could remove pock marks from their canvases, but contemporary females had to rely on heavy make-up and artfully applied beauty spots to cover badly scarred faces.

Servants who contracted the disease were thrown into the street to die.[3] Those who had not had the disease found it difficult to get employment.

Doctors prescribed strange treatment for smallpox victims. Usually they were crowded into small, windowless rooms where they lay for days in filthy clothing. Sometimes a regimen of fresh air and frequent changes of clothing were prescribed. Because freshly laundered clothing was considered unhealthy, a relative or friend first wore it.[4]

One doctor recommended that patients be given a spoonful of a mixture of white wine and sheep dung.[5] Men and women wore "sachets antivarioliques" around their necks for protection. With the sachets came precise instructions: men were to allow the sachet to rest over one breast, and women were to place it over the navel for best results.[6]

Smallpox, like most infectious diseases, did not respect social barriers. In the seventeenth century, Charles I of England lost two children to the disease.[7] Peter II of Russia died from it in 1730, on his wedding day.[8] In the United States, George Washington, the first president, owed his pock-marked face to smallpox, and Benjamin Franklin's four-year-old son died during an epidemic in the New England colonies.[9] (Franklin became one of the colonies' most outspoken advocates of inoculation.)

A year after Lady Mary's recovery, her husband was appointed ambassador to Turkey. There she heard about a strange practice.

Every fall, when the weather was cool, people gathered to have "the smallpox." An old woman would arrive at a home "with a nutshell full of the matter of the best sort of smallpox."[10] Each person was asked to decide which veins he wanted opened. Usually they were on the arms and legs where scars would be hidden. The woman made a scratch on a vein and inserted enough pus to cover the head of the needle. She then bound the wound with a hollow piece of shell. This procedure was usually repeated on three or four other veins.

Within a week of this inoculation, the patient began to display symptoms of smallpox; usually on the eighth day he spiked a high temperature that seldom lasted more than three days. Although pustules erupted on the skin, they rarely resulted in permanent scarring.[11]

This lack of scarring convinced Lady Mary that it was her duty to introduce the English public to the medical benefits of inoculation. She made a courageous decision to have her three-year-old son inoculated, and asked Dr. Charles Maitland, the embassy physician, to witness the procedure.[12]

The old Greek woman who was asked to perform the inoculation caused the boy so much pain that the doctor took the needle away from her and injected the pus into the child's veins himself. In March 1718, Lady Mary wrote the following letter to her husband:

"The boy was engrafted last Tuesday, and is at this time singing and playing and very impatient for his supper. I pray God my next (letter) may give as good an account of him."[13]

Little Edward Wortley completely recovered from the mild case of smallpox that followed and was left without any scarring.

The English medical world received the news of this inoculation with amused interest and skepticism. As one doctor later wrote, "It was an experiment practiced only by a few ignorant women amongst an illiterate and unthinking people."[14]

Lady Mary believed that inoculation was a Turkish discovery; however, the practice had been used in some parts of the world for centuries. Since early times the Chinese had been inoculating the virus into the skin or drying smallpox matter into a powder that was blown into the nostrils.[15] African tribes had been known to inoculate themselves against the disease.[16] In Northern Scotland it was common to allow children to sleep in bed with members of the family who had smallpox, or to soak material with smallpox matter and tie this on the arms of small children.[17] Doctors there considered it so important to contract smallpox in early childhood that they often took their young children to homes of patients convalescing from a "favorable kind" of smallpox.[18] Most English doctors knew about inoculation but rejected the idea.

When Lady Mary returned to England, another smallpox epidemic struck. Because her son's inoculation had been dismissed as inconclusive, she decided again to bring the procedure to the attention of laymen and the medical world. She asked Dr. Maitland to inoculate her daughter who had been born in Turkey. Maitland at first refused, but later, with three doctors as witnesses, he inoculated the little girl.

Once again, news of the successful inoculation created widespread interest and comment. One of those most interested was Princess Caroline, daughter-in-law of George I, who had long feared that her three daughters might die of smallpox. Not convinced of the safety of inoculation, she chose six condemned convicts in Newgate prison and offered them full pardon if they submitted to the "Turkish invention."[19] The now famous Dr. Maitland acted as their physician.

For days after their inoculation, newspapers carried extensive reports, and hundreds of people flocked to stare at the prisoners. One man, who already had had smallpox, did not show any signs of the disease. The others, who developed mild cases, recovered without any ill effects. They left Newgate as happy testimonials to the relative safety of inoculation.

But Princess Caroline was still not ready to allow her daughters to be inoculated. To test its safety further, she ordered the inoculation of 11 orphans, including five infants. Their complete recovery from mild cases of smallpox provided the proof she needed. Later, Dr. Claude Amyand, the royal physician, inoculated two of her children.[20]

Almost immediately, English society began to debate the wisdom of this Royal approval of inoculation. Many of Lady Mary's family and closest friends refused

to be inoculated. One of these skeptics, Lady Mary's sister, lost a son to the disease two years later.

Nevertheless, more and more people began to ask to be inoculated. Between 1721 and 1728, 897 people were inoculated; 17 died as a result. During the same period, 18,000 people died from active cases of smallpox.[21]

Some historians believe that inoculation resulted in more cases of smallpox in England. This may have happened occasionally because many doctors did not realize that inoculated patients were as infectious to others as were people with active cases of the disease.[22] At a time when sterile technique was unknown, deaths sometimes occurred when doctors used filthy, blood-encrusted needles for inoculations. Some patients were weakened from bleeding before the inoculation was performed.[23] Matter taken from a recently inoculated individual was sometimes used, usually resulting in mild cases of smallpox that did not provide permanent immunity.[24]

As inoculation became increasingly popular, hospitals were built where people could be inoculated and convalesce under the watchful eyes of physicians. Patients were asked only to make a deposit of one pound, sixpence, to cover burial expenses, a sign that there were still misgivings about the safety of inoculation. Smallpox hospitals were frequently forced to move because of local citizens' complaints. Between 1746 and 1750, almost 4,000 people were inoculated at these hospitals.[25]

After her daughter's inoculation, Lady Mary spent several years defending the procedure she had helped to introduce into England. To answer critics of inoculation, she wrote an anonymous essay, "A Plain Account of the Inoculating of the Smallpox by a Turkish Merchant." It was only recently that Lady Mary was proven to be the author of this controversial essay.[26]

Lady Mary died in 1762 of cancer of the breast. Only a small monument in a quiet English churchyard serves as a memorial to her. The inscription on the monument reads: "Sacred to the Memory of The Right Honourable Lady Mary Wortley Montagu who happily introduced from Turkey The Salutary Act of Inoculating The Smallpox."[27]

Did inoculation play a part in the famous experiment that was to earn Jenner immortality?

Perhaps, for in recent years some scientists have suggested that cowpox may have been inoculated smallpox.[28] What may have happened was that inoculated farmers and milk maids scratched itchy pustules on their arms, and the infectious matter beneath their fingernails was transmitted to cows' udders. This accidental infection of human smallpox may have been the accident that provided Jenner with vaccination. The infected cows developed a milder, related type of disease resulting in a live virus that stimulated the production of antibodies capable of defending the body against an attack of a deadlier organism.[29]

Women like Lady Mary exist in any century. They are the people who accept the risks others are afraid to take. Nurses meet them often during their careers — a patient who undergoes a kidney transplant, well aware of the hazards involved; a mother who agrees to have her child, suffering from leukemia, receive new, experimental drugs. Without the fortitude of these pioneers, medical progress would be impossible, for people like these are the real heroes in the continuing battle against disease.

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books

Comprehensive Cardiac Care. A handbook for nurses and other paramedical personnel, by Kathleen G. Andreoli, Virginia K. Hunn, Douglas P. Zipes, and Andrew G. Wallace. 153 pages. Saint Louis, Mosby, 1968.
Reviewed by Mary Alexander, Lecturer in Medical-Surgical Nursing, McMaster University, Hamilton, Ont.

This text describes the essentials of comprehensive cardiac care with which nurses and other paramedical personnel should become familiar in order to recognize the warning signs of cardiovascular emergencies and to implement appropriate therapy promptly.

The text begins with a brief review of the anatomy and physiology of the heart. Each structure and its function are given side by side with illustrations, which facilitates easy review of the subject. Following is a section on physical examination of the cardiovascular system; with each method of diagnosis, the normal manifestations, followed by the abnormal, are explained. In describing coronary heart disease and its complications, the pathological manifestations according to the type of blood vessel involved are detailed, and a brief but complete description of clinical syndromes, such as angina pectoris, myocardial infarction, congestive heart failure and cardiogenic shock is included. Related topics that need to be reviewed (but an elaborate description of which seems beyond the scope of the book) are indicated in tables; for example, the treatment of acute pulmonary edema.

Basic electrocardiography is ably described, perhaps in greater detail than seems necessary for nurses and other paramedical personnel. An understanding of leads I, II, and III, as well as cardiac arrhythmias, would have sufficed. Cardiac arrhythmias are described with figures according to their place of origin in the heart. Prior to a description of this, the electrical pattern of the cardiac cycle, time lines of the electrocardiogram, the method of calculating heart rate, and the conduction of normal sinus rhythm are well elaborated. The purpose, indications, methods, and complications of temporary as well as permanent cardiac pacemakers are specified. The final chapter gives a clear and comprehensive picture of the care of the cardiac patient.

There are four appendices in this book. Appendix A presents some of the significant drugs in cardiac disorders. Electrocardiogram tracings showing the normal as well as toxic effects of digitalis and quinidine are given. Appendix B describes disorders other than myocardial infarction and compares the nature of chest pain in these, enabling one to differentiate myocardial ischemia from other clinical problems. Finally, appendices C and D are two test selections that are invaluable for a review of arrhythmias and electrocardiography.

This book on the whole is an excellent manual on cardiac care and a good source for a quick review of the subject. A reader with some background knowledge of the cardiovascular system and its disorders could well understand the subject matter due to its clarity of style and lucidity of expression, as well as the illustrations and electrocardiogram tracings that are included. Although brief, the text is exhaustive and has definite continuity from one chapter to the other. Each chapter concludes with extensive references. These features make it a valuable reference book for nurses and paramedical personnel.

Antibiotic and Chemotherapy, 2nd ed. by Lawrence P. Garrod and Francis O'Grady. 475 pages. Edinburgh and London, E. & S. Livingstone Ltd., 1968. Canadian agent: Macmillan Co. of Canada Ltd., Toronto.
Reviewed by Dean M. J. Huston, Faculty of Pharmacy, University of Alberta, Edmonton, Alberta.

The preface to the first edition of this book states that it is "mainly about antibiotics, sulphonamides and other synthetic drugs employed in the chemotherapy of microbic infections." This welcome second edition is much more than a textbook on materia medica or a pharmacopoeia as that statement might suggest.

The book is divided into two parts. Part one, dealing with the properties and uses of the antimicrobial drugs, has been revised and brought up-to-date with the addition of many newer antibiotics and other synthetic antimicrobial drugs currently in use. In addition, current knowledge concerning the development of drug resistance by various pathogenic microorganisms and the mechanisms of antimicrobial activity of many of the drugs is presented concisely in tables and figures.

Part two consists of a discussion of current concepts in the treatment of most of the common microbial infections. This part of the book is an excellent source of up-to-date information on causative microorganisms and secondary invaders in microbial infections. The various infections are grouped according to anatomical location, which should facilitate use of the book by clinicians. The information presented in this section has been taken from recent publications. Only the pertinent facts have been selected, condensed, and compiled in a form that provides a maximum yield of information in a minimum reading time.

Laboratory workers will find the second part of this book particularly useful. It provides a compendium of bacterial sensitivity tests and antibiotic assay procedures, some of which may not be found elsewhere.

At this time when the influence of 25 years of antibiotic chemotherapy is being reflected in unpredictable alterations in what may be called the "traditional" etiology and treatment of infectious diseases, an up-to-date source of information regarding current trends and concepts is essential to all who treat infected patients, work in pharmaceutical or clinical laboratories, or advise clinicians.

History, School of Nursing, Toronto General Hospital, vol. 2, 1932-1967, by Mary E. Macfarland. 59 pages. Toronto, McGaw-Jordan Ltd., 1968.
Reviewed by Mrs. H.G.M. Colpitts, President, Ottawa Chapter, Toronto General Hospital Alumnae.

This soft-cover book recounts the history of the TGH School of Nursing, providing the reader with a clear picture of the progress and development during the years 1932-1967.

A brief reference is made to the inception of the training school. Of particular interest is the information that the two nurses responsible for the training of the first class of students were "to receive each one hundred dollars a year for their services in connection with the school." The year was 1881.

It is refreshing to read a textbook written by someone dedicated to her work, who can transmit this enthusiasm to the reader.

The book speaks of problems that existed during the depression and war years, and points out the dramatic and rapid change of the last 20 years. It clearly reflects the modern attitude

books

toward nurses and nursing, and is almost a chronicle of nursing itself.

While education of the student has been broadened in scope and has undergone innumerable changes, social and cultural activities have been recognized as important aspects of development of the person.

Included in the history, although not part of it, are descriptions of new buildings, refurbishing, and refurnishing, which vitally affect the School's functions. Tribute is paid to many of the "history-makers," whose record of service and devotion is unparallelled.

The book is well and liberally illustrated. Many of the pictures will evoke a "do you remember? " from the readers, particularly those who graduated a few years ago.

Since both chronological and topical approaches are used, the reader must remain alert. The author has avoided boring detail; she has condensed a proud record of achievement into a fascinating and very readable narrative.

Anyone who is charged with the task of compiling a history of a school of nursing will greatly benefit from this volume. All TGH graduates and those associated with the hospital will find the book interesting and nostalgic.

Essentials of Communicable Disease With Nursing Principles, by Dorothy F. Johnston. 400 pages. Saint Louis, Mosby, 1968.
Reviewed by Sally Tretiak, Red Deer Junior College, Red Deer, Alberta.

The value of this smoothly written, easy-to-read book lies in its comprehensiveness. It would be excellent for overall teaching purposes.

The content is divided into six sections. The introduction deals with historical events, scope of control, immunology, social, psychologic and economic factors, and nursing patients with communicable diseases. The remainder of the book classifies diseases according to the causative factors, including bacteria, viruses, arthropod vectors, fungi and helminths. Each chapter has a list of references and each section contains review questions, a bibliography, and a listing of films that could be used in conjunction with the book.

The sections on nursing care give a clear description of procedures. However, the student would need a good background of physiology and microbiology and a pathology reference at hand to understand the specific disease processes.

For a comprehensive listing of communicable diseases in man and for methods of their control, one would have to go to official publications. No textbook can do this, and this one rightly concentrates on the nursing care of the patients.

The Operating Room Technician, 2nd ed., by Sister Mary Louise. 282 pages. Saint Louis, Mosby, 1968.
Reviewed by Miss K.L. Cook, Head Nurse, Operating Room, Whitehorse General Hospital, Whitehorse, Yukon Territory.

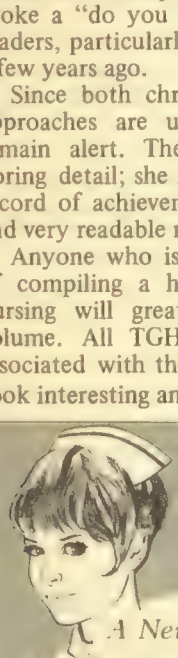
In the foreward, the author stresses the fact that, as a text, this book should be used in conjunction with a planned curriculum of training in practical operating room duties.

The book, centered wholly on the patient's welfare, is written in a clear and understandable way. Each chapter is headed by a summary, or list of subjects it contains and new terms that are introduced, making it easier for the student to look up any reference. There are questions at the end of each chapter.

The first chapter, which briefly outlines hospital management, illustrated with a graph, gives all the positions and services in a hospital and stresses the role of the operating room technician in the structure.

All the salient points of patient care before, during, and after surgery are covered. One excellent chapter, "essentials for the procedure," covers sponges, their composition and uses, dressings, syringes, needles, connectors, and adaptors.

The book is well illustrated, and shows, step by step, such procedures as the "closed glove method," and opening



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suture packs and dressings. Sutures and different types of needles are shown. There are also illustrations of instruments divided into group types, e.g., holding forceps, clamps, retractors, and speculi.

Instead of interrupting the trend of a chapter, the author has included 25 appendices that cover such subjects as the objectives of each person in the operating room, room clean-up routine, electrosurgery in the operating room (including an interesting short history), topical outlines of microbiology, pharmacology, psychology, operating room fundamentals, and techniques. These would be excellent guides for the operating room instructor or supervisor who teaches student technicians. □

films

Immediate Post-Surgical Prosthesis – 16 mm., 30 minutes, color and sound. Available without charge on loan from Miss Anne Gilbert, c/o Johnson & Johnson, 2155 Boulevard Pie IX, Montreal 403, P.Q.

Several case histories are described that concern the management of lower extremity amputees at the Prosthetic Research Study in Seattle, Washington. The psychological and economic advantages of immediate post-surgical fitting technique are illustrated effectively.

This film would be of special interest to nurses working in the field of rehabilitation.

Overcoming Resistance to Change – 16 mm., 28 minutes, black and white or color, sound. Produced 1962. Sale Price b/w $185, color $315. Available on loan from Canadian Film Institute, 1762 Carling Ave., Ottawa, for a small rental fee.

This film outlines how various people react to proposed change and how each one is taught to deal with it effectively. Employees in a business situation are unhappy about moving to a new plant. Their manager is shown gaining sudden insight into their problems and then presenting specific ways to deal with each. Although this film is not new, it demonstrates well the fundamental principles that are applicable to any situation involving change.

It is well-organized and clearly presented, and would be a good training film for nursing personnel.

Robin, Peter, and Darryl: Three to a Hospital – a new 16 mm., 53-minute, black and white motion picture developed by the multidisciplinary faculty of the Department of Nursing, Faculty of Medicine at Columbia University. Available on loan from the Canadian Film Institute, 1762 Carling Avenue, Ottawa, for a small rental fee.

Events in the film are not staged. Rather, the camera captures the fears, tears, and frustrations of the three children as they express them during their hospital stay. The film would be useful to teach nursing students about effects of maternal separation and children's reactions to hospitalization. Content and technique are designed to stimulate the student's imagination and elicit classroom discussion.

Emergency 77 – 16 mm., 14 minutes, black and white, sound. Available without charge on loan from Metropolitan Life Insurance Company, 180 Wellington St., Ottawa 4.

This film presents several emergency situations faced by individuals, their families, and their doctor in a typical community. The importance of knowing what to do quickly in an emergency requiring medical attention is well documented and is based on actual emergencies. Emphasis is placed on avoiding panic through knowledge, planning, and practice. As a teaching tool it is suitable for anyone concerned with his own health and safety and the well-being of family and community.

The Way I See It – 16 mm., 23 minutes, black and white, sound. Available on loan from Canadian Film Institute, 1762 Carling Ave., Ottawa, for a small rental fee.

This is an open-ended film designed to stimulate thought and discussion on such questions as:

1. To what extent do perceptual differences influence job performance?
2. Why do people see themselves so differently from the way others see them?
3. How can a manager know what his people think of him?

May be useful for preparing head nurses to function in managerial positions, or supervisors to evaluate personnel.

Hyperbaric Fire Control — Fire Behavior and Extinguishment in Hyperbaric Chambers – 16 mm., 20 minutes, color, sound. Prepared in 1965 by Roman L. Yanda, M.D., Los Angeles, in cooperation with the Los Angeles City Fire Department, California State Fire Marshals Office. Indicate desired and alternate showing dates. Available on loan from: Film Library, USAF School of Aerospace Medicine, Brooks AFB, Texas 78235.

Hyperbaric oxygen therapy is a new technique being developed for the treatment of certain disease conditions. Although it is still experimental, the technique is being utilized in this country and in Europe on an increasing scale. One of the serious problems associated with hyperbaric oxygenation is the fire hazard. Anything that burns in air ignites more readily and burns more rapidly in oxygen or in compressed air.

This film depicts graphically the fire hazards associated with the use of a hyperbaric chamber. Mannequins dressed in conventional hospital clothing are set afire in atmospheres of compressed air to demonstrate vividly how rapidly cotton fabrics will burn and how difficult the fires are to extinguish. Smothering with blankets is ineffective. Large volumes of water are required. Shown and discussed are extinguishment techniques, methods of mitigating fire hazards, and suggestions for fire safety programs in hospitals in which hyperbaric facilities are in use.

This motion picture is directed at all levels of personnel involved in hyperbaric-facility design, operation, and maintenance. Physicians, nurses, chamber technicians and operators, and hospital engineers and architects who are concerned with the use of a hyperbaric chamber will find much valuable information. It is not recommended for showing to lay groups in general since a potential candidate for hyperbaric therapy might refuse needed treatment were he to view the vivid fire scenes. □

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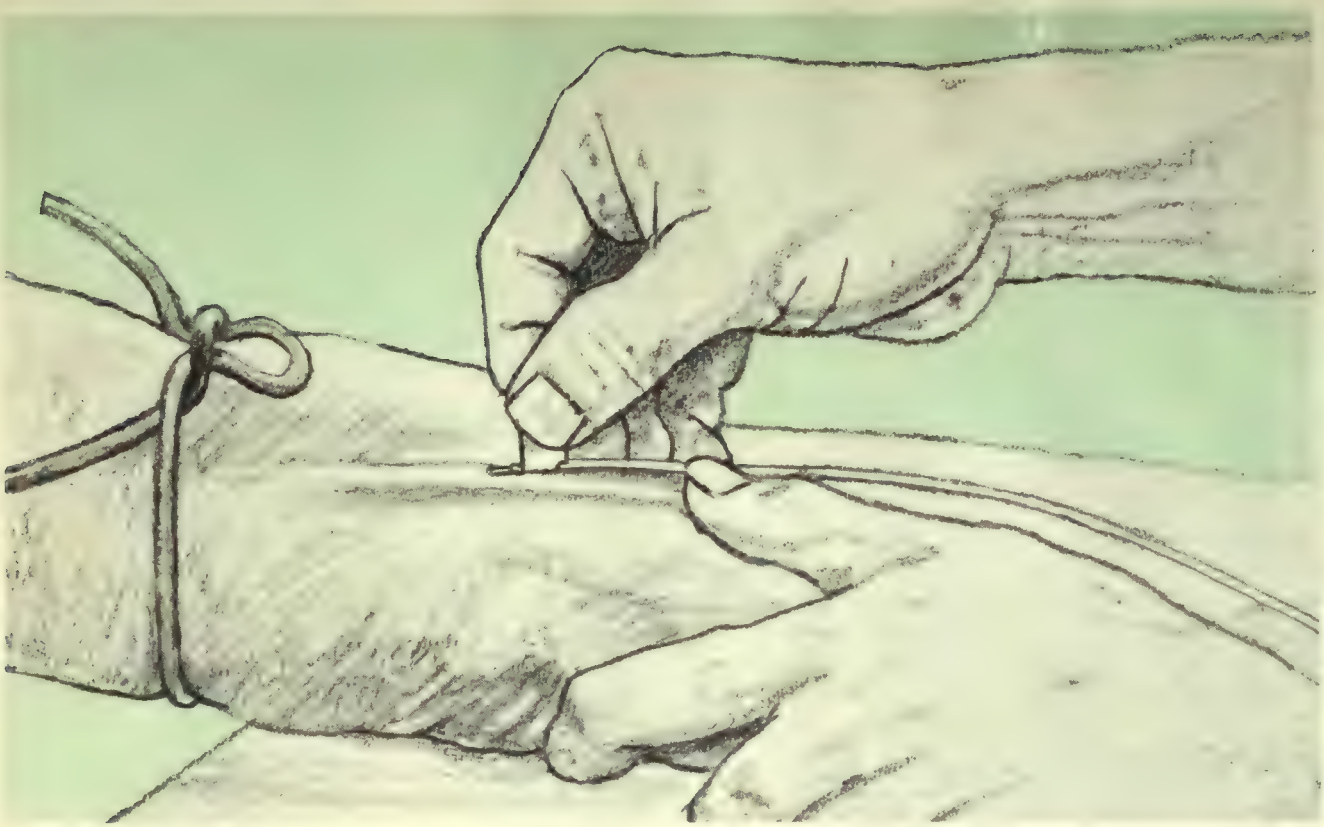


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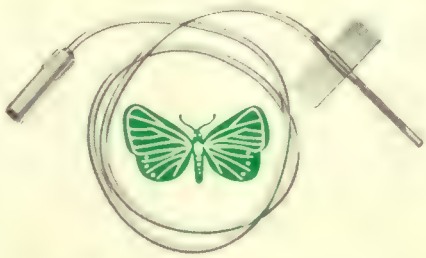
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References: 1. Beck, J.W., Saavedra, D., Antell, G.J., and Tejeiro, B.: Am. J. Trop. Med. **8**:349, 1959. 2. Sanders, A.I., and Hall, W.H.: J. Lab. & Clin. Med. **56**:413, 1960.

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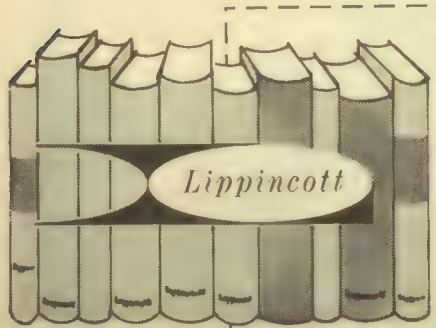
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The Canadian Nurse

A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

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The bang of the gavel that officially closed the 14th Quadrennial Congress of the International Council of Nurses in Montreal on Friday June 27 brought mixed feelings to many: relief that the event – so long planned for – was over; and regret that it had ended so quickly.

The amount of detailed planning and work that went into this congress is unbelievable. That the congress was a success is due to the efforts of hundreds of persons.

We got a fair amount of feedback from nurses at the congress. These nurses found the church service at Notre-Dame Cathedral to be the most inspiring event. Although it was extremely hot and crowded they sensed a real feeling of oneness. The opening ceremony on Sunday night was listed by these nurses as the most colorful event. They were particularly impressed by the dignity, warmth, and humor of the Governor-General.

Canada's Minister of Health, the Honourable John Munro, received the most votes from these nurses as best speaker of the week. Also high in their estimation were the special interest sessions.

We would be departing from our usual practice of editorial frankness if we ignored the criticisms voiced by these nurses. They complained about the registration lineups; the mediocre acoustics in Concordia Hall, particularly for those who had to rely on earphones for translation; the problems they had in seeing the speakers when the dias on the platform was not revolving; and the impossibility, because of the number of persons attending the congress, of feeling a sense of "unity" with others.

These nurses agreed, however, that the congress had been a tremendous success. As evidence, they expressed the hope that they could find the time and funds to attend the 15th Quadrennial Congress in Mexico in 1973. – **V.A.L.**

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Two-year vs. three-year programs

I am gratified to see the active thinking going on in the minds of Canadian nurses in reading our article "Two-Year Versus Three-Year Programs (Feb. 1969). However, while we might be to blame for not having used block letters in printing some of the key points in this report, I believe the readers would do well to get used to small print as well. For example, the sixth paragraph notes: "Both the experimental and the control students . . . " followed a similar program, except that one was one year longer. And as part of the conclusion: " . . . the difference in favor of the controls is not so marked as to justify an extra year of education."

I would like to reaffirm that even if some results were in favor of a program similar, but one year longer, I am firmly convinced that the hypothesis stated in the first paragraph proved to be true in this experiment. Nursing students can be adequately prepared for the demands of the profession and society in less than three years providing the whole program is geared toward that goal. The fact that the graduates of this experimental program have met the registration requirements and the employers' expectations speak in favor of this shorter program. This voice, we hope, will be heard by many and should be encouraging for all who are engaged in the "renewal" of nursing education.

In conclusion, may I assure the readers that we are not suggesting that our research project and report were flawless. On behalf of the faculty and students who participated in this five-year experiment, we would like to thank all those who showed some interest in it and see some credit in an effort that we believe should have some bearing on the advancement of the nursing profession in Canada. – Sister T. Castonguay, St. Louis, Mo.

Nursing director can evaluate

In her letter entitled "Smug Disrespect toward doctors" in the January issue, Carole Stafford has pointed out the dilemma present in the nursing profession today.

She asks, "Does the nurse interviewer assume that the director of nursing from her office can better assess the nurse's capabilities than the surgeon to whom she passes the instruments? "

The fundamental issue here, of course, is whether nursing as a profession is able to plan, assess, and evaluate its services in the health field. I, for one, do not believe that the surgeon is better qualified to evaluate the nurse than is the director of nursing.

The director has among her staff, people who are accountable to her for the evaluation of nursing personnel. She does not glibly evaluate "from her office." – A. Joyce Bailey, Reg.N., Toronto.

Students' association

With reference to the item "Students Discuss Pros and Cons of Own Provincial Association" (News, June 1969), I would like to give a few observations of my own that might be of interest to those who plan to organize such an organization on the provincial level and those whom the organization will represent.

As a student nurse in England, I was, during my three years of training, chairman in my own hospital unit, of the Student Nurses' Association of Great Britain, and eventually the representative of all the Western Counties and a member of the executive council at the national level.

At that time there were some 20,000 members of the SNA with units at each hospital. The Council consisted of 26 elected members with a paid secretary, a non-practicing registered nurse. It was organized as an independant body under the auspices of the Royal College of Nurses.

In the two years that I served at the national level I really had an eye opener. I found that there were many enthusiastic people in our organization, anxious to be heard and help effect changes for the general good. But for every one enthusiastic member, 20 or more were apathetic and uninterested. The few who were enthusiastic endeavored to make the organization a viable, meaningful institution, sometimes against overwhelming odds and many frustrations. It was unfortunate, as the students were often the people who really had knowledge of situations that could be improved.

Although the executive council fought bravely, their enthusiasm and energy was drained and strangled in a red tape jungle. Many of the senior members of the profession were only prepared to encourage the SNA if all it did was have afternoon teas or sponsor outings for the local Old Folks Home. The blame was not with these people entirely. Worst of all were the students themselves, who sat apathetically in their hospitals and never worried about what became of their professional association, in spite of repeated efforts of the SNA national council and the enlightened members of the Royal College to stir up a thinking, meaningful group to make recommendations for reform in areas where it was needed.

Yes, student nurses of Ontario, do have an organization, you have much to contribute and I wish you well. But remember, every student has the onus to contribute something to the endeavor; or, like the Student Nurses' Association of Britain, you will fail in spite of the valiant efforts of those who wanted to do so much for the students' benefit. – Margaret Side, Lieutenant, Canadian Armed Forces. □

Have you a Christmas Story Or Message To Share?

The Canadian Nurse

invites readers to submit original articles about Nursing at Christmas for possible publication in the December 1969 issue.

Manuscripts should be typed double-space on one side of unruled paper, leaving wide margins. The usual rate will be paid for accepted material.

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news

Students Want Voice At ICN Begin To Speak Out On Issues

Montreal, P.Q. – By far the largest number of students ever to have attended an ICN Congress – 700, compared with 300 in Germany in 1965 – were in Montreal June 22-28 as invited observers. Their varied program, organized by the Association of Nurses of the Province of Quebec, began on a light note Monday evening with colorful folklore dances, but ended with a panel discussion Thursday night that aroused heated debate among the students.

It was Thursday's panel discussion, "Students on the March," that brought out many voices of dissent and focussed on issues that will have to receive more attention in the future – if students have their way.

In his introduction to the keynote speaker, Dame Muriel Powell, Jean-Pierre Ruest, president of Montreal's Association of Student Nurses of the Province of Quebec, began the discussion of student protest. The brightest young people, he said, are involved in protest against wars, assassination, military takeovers, and the injustices of the South African government. It is up to young people to reject whatever breaks down humans, he told the student audience.

Dame Muriel Powell, matron and chief nursing officer of St. George's Hospital in London, England, said that the satisfaction inherent in the job of the nurse may be responsible for the failure of nurses as a whole to organize themselves as a professional group, for slowness in reforming nursing education, and for the acceptance by nurses of poor remuneration and long hours of work. But this situation is changing, she pointed out. Issues such as transplant surgery, birth control, and the legalization of abortions concern the nursing profession, and nurses must be able to play their part in any public debate and discussions, she said.

Dame Muriel, quoting George Bernard Shaw, told her audience, "all that the young can do for the old is shock them and bring them up to date."

Following this speech student panel members from Switzerland, New Zealand, and the United States spoke. Ariane Randell from Geneva explained how the 150 students at Le Bon Secours Hospital participate in decision-making through a student council and through student evaluations of their teachers and the program. The goal, she said, is for students to plan their own programs in the future, with teachers only to guide.

Florence Huey, a recent graduate of Louisiana State University's school of nursing, asked why there has not been more student nurse protest. The audience applauded when she said that nursing education has perpetuated the isolation of nursing students from other students. The nursing student movement is 10 years behind, she added. She concluded that the future will be determined by the ability of nurses not to be content with the status quo, always to grope for change, and to question.

Then the audience made their views known. One student nurse from the United States said that the students at the Congress had been served a grave injustice. In each plenary session in which the role of the student was discussed, no one invited a student to express her viewpoint. It is only tonight that we have the opportunity to discuss our views

(Continued on page 8)

ICN Congress Breaks All Registration Records



Montreal, P.Q. – A record number of nurses came from 85 countries to attend the quadrennial Congress of the International Council of Nurses June 22-28.

Canada had the highest registration with 2,800 nurses attending, followed by the United States with 1,870, and the United Kingdom with 740. Total daily registration came to slightly more than 1,000.

Twenty-seven national associations sent observers to the Congress. Of these associations, 11 had applied for ICN membership and all were successful. Argentina, Bermuda, Bolivia, Costa Rica, Ecuador, Lebanon, Morocco, Nepal, Portugal, Salvador, and Uganda are new members of ICN.

The eight nurses here catch some of the international flavor created by the colorful variety of national costumes that were worn throughout the week. These representatives (clockwise from front center) from Switzerland, Ceylon, Canada, Japan, England, United States, and Zambia, are admiring a floral replica of the Congress symbol. The flowers – red sweetheart roses on a background of white chrysanthemums – were a salute from Interflora, an association of florists from 90 countries.

Full congress reports are carried throughout the journal.

Hospital Nurses In NB Submit Mass Resignation

Fredericton, N.B. – The New Brunswick Association of Registered Nurses' negotiation committee announced that on July 15, 1,369 registered nurses employed in public hospitals offered resignations to take effect August 15. This is 90 percent of those nurses in the hospital nursing force in a bargaining unit.

"We expect the number to increase, because we were unable to contact 118 nurses now on vacation," said Marilyn Brewer, spokesman for the nurses' negotiation committee. Mrs. Brewer also said that the nurses are prepared to provide emergency services and will discuss these with management.

The decision to withdraw services came at a meeting of the provincial collective bargaining committee July 4. The 10-member committee, representing the five provincial regions, has three of its members on the negotiation committee. The committee brought the results of a poll conducted among hospital nurses during the last week in June to determine nurses' willingness to resign if necessary.

As reported in the July issue of *The Canadian Nurse* negotiations with the New Brunswick Hospital Association broke down in June when the NBHA refused to make a realistic offer to nurses. Current 1969 salaries for registered nurses in New Brunswick are $373 per month, the lowest in Canada. The Canadian Nurses' Association recommends $500 per month basic remuneration for a registered nurse.

Resignation was the only course open to the nurses because the Public Service Labour Relations Act of New Brunswick, although passed in December 1968, has not yet been proclaimed. This move is necessary before nurses could strike.

In an interview with Glenna Rowsell, the newly appointed Employment Relations Officer of the New Brunswick Association of Registered Nurses, she said: "I think the government and the Hospital Association got a shock when they realized how well prepared the nurses were for collective bargaining. The quality of the counter proposal by NBHA did not reflect the quality and worth of the registered nurse," she added.

(Continued from page 7)

– but with each other, she continued. "If we must financially support this Congress, we're entitled to more participation." She recommended that at the next Congress a student session be held earlier in the week to allow students to voice their opinions strongly in the plenary sessions.

"Marvellous, you're getting a bit angry now," Dame Muriel replied. "I'm sure that at the next Congress they will be listening."

A recent U.S. graduate said that the students had been letting him down. At the open sessions many questions were nebulous and pointless, he said. "Where were the students?" "Too often you're told you're the leaders of tomorrow. You're the leaders of today!"

Dame Muriel said that only ICN members were allowed to speak at the open sessions. It was only in 1961 that the first students were invited to attend the ICN Congress, she reminded the audience. "Things take a long time." She strongly advised the students to press through their national associations to get into the ICN. It would be very helpful to have the student point of view, she said.

Association's Aims Too Remote Says MARN President

Brandon, Man. – "Aims were too far removed from the immediate problems facing the [association's] provincial board and office to be realistic," said Dorothy Dick, president of the Manitoba Association of Registered Nurses. She was speaking at the annual meeting of MARN in Brandon, May 29-30, 1969.

Miss Dick went on to discuss other problems facing the association, including the shortage of professional staff and the difficulties she encountered as president, having had no experience in the board in the previous biennium. She traced the actions of the association over the past four years, identifying the problems and discussing possible solutions to them. The opening of the new MARN headquarters was one of its greatest accomplishments, said Miss Dick, providing more office space for staff and better facilities for membership. The problem of apathy in the association was attacked by visits to local groups, often by the social and economic welfare committee, she reported.

Other speakers at the annual meeting included O.A. Schmidt, president of the Manitoba Medical Association, and G.E. Chapman, administrator of the Brandon General Hospital, speaking for the Manitoba Hospital Association. The Hon. Sidney J. Spivak, Manitoba minister of industry and commerce, was the keynote speaker. His address was titled "Health needs in Manitoba in the second century."

A panel presentation moderated by Shirley Jo Paine discussed "Where is nursing going in 1970?"

No Salary Increases Offered

Toronto, Ont. – The Nurses' Association of the Clarke Institute of Psychiatry has not reached an agreement with the Institute over salary increases. After six months of meetings there has been very little progress, according to a release issued by the Association June 23.

The negotiating committee of NACIP has been meeting regularly with representatives of the Clarke Institute since January. Some progress has been made on non-monetary items.

The Institute offered no salary increases at a conciliation meeting in May, although NACIP claims its employees are "the most poorly paid psychiatric nurses in the province."

NACIP feels the Ontario Hospital Services Commission is limiting the Clarke Institute at the bargaining table whenever monetary items are discussed.

In late June NACIP notified the Institute of its nominee to a board of arbitration. The employer's nominee is still to be named.



Dame Muriel Powell (center), keynote speaker at Thursday evening's panel discussion, "Students on the March," talks with two of the student nurse participants. This was the final event of the four-day student program at the Congress of the International Council of Nurses in Montreal held June 22 to 28.

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news

(Continued from page 7)

3M Donates Fellowship

Montreal, P.Q. – The 3M Company has offered an annual grant of $6,000 to continue education of nurses chosen from among the members of national nursing associations affiliated with the International Council of Nurses.

The grant, to be called the 3M Nursing Fellowship, will be awarded annually to a nurse selected by the ICN. The money may be used at his or her discretion for formal study in the nurse's chosen field of interest.

The award will be made to a nurse who is a member of her own national nursing association, who has had at least two years nursing experience after graduation and is active in nursing. Each national association will submit the name of one candidate to the selection committee, which will consist of the ICN president, three vice-presidents, and the executive director.

Roy W. Keeley, executive vice-president and general manager of 3M, Canada, presented a scroll confirming the 3M Fellowship to Alice Girard, president of ICN, at the Quadrennial Congress of ICN. "We hope and expect that the 3M Fellowship will assist the development of nursing knowledge on an international basis," Mr. Keeley said. "The ICN, as the international body of professional nurses, is the logical organization to administer these funds."

The 3M Company is a world-wide manufacturer of numerous products, including surgical and various cellophane tapes. They also produce photocopy machines and donated services of two 3M Photocopiers during Congress sessions.

White Sister Donates $30,000 Scholarship

Montreal, P.Q. – A $30,000 scholarship fund for Canadian nurses has been donated to mark the 14th Quadrennial Congress of the International Council of Nurses, June 22-28. White Sister Uniform Inc. announced the donation during the Congress in Montreal.

The fund will be donated in 10 yearly installments of $3,000 to the Canadian Nurses' Foundation by the Montreal-based company. It will be awarded to one or divided among two or three graduate nurses for continuation of their studies.

Norman Lupovich, president of White Sister, said the fund is being donated to commemorate the magnificent scope and magnitude of the Congress and to recognize the superb effort of the Canadian Nurses' Association, host of the Congress. A commemorating certificate and medal of honor will be awarded with each presentation.

White Sister intends to reestablish the scholarship after 10 years. The company has asked that the scholarship be awarded provincially on a rotating basis.

"Nurse In Society" Is AARN Convention Theme

Edmonton, Alta. – Pediatric nursing, drug addiction, alcoholism, and mental health were some of the topics that fell under the theme "Society – the Nurse's Role" at the annual convention of the Alberta Association of Registered Nurses. The convention was held May 13-16 in Edmonton.

Loretta D. Ford, professor of public health nursing at the University of Colorado in Denver, spoke to some 600 nurses following a luncheon on the topic of pediatric nurse practitioners. She described an experiment taking place at the University of Colorado in which nurses are trained to assume part of the pediatrician's role in examining children, and to refer only those requiring medical attention to the doctor. She stressed that they were not producing another type of health worker, but training the nurse to assume more responsibility.

Other speakers included Albert Rosentein, a psychologist from California, and Howard Levitt, a probation officer with the Los Angeles county probation department, who discussed drug addiction; Fil Fraser of the Alberta division of alcoholism, who spoke on alcoholism; and Dr. W.N. Blair, who reported on recent findings of his study on mental health in Alberta.

The speakers were brought together after the presentations to answer questions from the audience.

Geneva Purcell, president of AARN, reminded members in her address that the AARN must speak for the profession as a whole, yet allow the individual nurse to express assent or dissent. "The effectiveness of an organization is dependent upon the active participation of its members," she said. "The association needs the vision, intellect, the will and cooperative effort of each individual."

Brief reports were also presented on the new two-year nursing program by Marguerite Schumacher, director of nursing at Red Deer Junior College, and members of the AARN advisory committee to the study.

During the convention, the Board of Directors reelected Miss Purcell as president for a two-year term. Roseanne Erickson was elected to the new position of president-elect.

ANPEI Holds Annual Meeting

Charlottetown, PEI. – One-hundred-twenty-three nurses from across the province attended the 48th annual meeting of the Association of Nurses of Prince Edward Island held June 10.

(Continued on page 12)



Roy W. Keeley, executive vice-president and general manager of 3M Canada, presents to Alice Girard, president of ICN, the scroll confirming the 3M fellowship to ICN at the 14th Quadrennial Congress in Montreal.



Norman Lupovich, president of White Sister, discusses the $30,000 scholarship donated by his company to CNF with Rita Lussier, analyst at the center for evaluation of positions in Quebec Hospitals at the ICN Congress in Montreal.



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(Continued from page 10)

Main resolutions passed were:

- Every member and former member of ANPEI will be asked to write something for inclusion in a history of the association, to be published for the 50th anniversary of ANPEI in 1971.
- ANPEI is to organize workshops for doctors and nurses to discuss team health care.
- The Association is to approach the local medical association regarding the establishment of a pilot project in home care.
- The four branches of ANPEI will plan to raise at least a dollar per member for the Canadian Nurses' Foundation as an annual project.

A panel discussion on team health care was a highlight of the meeting. Chairman for this panel was Dr. Burton Howatt, assistant deputy minister of health for PEI.

"Things take time" was the theme chosen for an address by ANPEI President Bernice Rowland. She related this to changes taking place in the province in the areas of nursing education and labor relations.

Miss Rowland mentioned three schools of nursing are about to be replaced by one in the province as a result of studies and workshops. Nurses have also improved health care practices in their individual work units, she added.

Miss Rowland then discussed the new nurses' bill, which has not yet been passed by the provincial government. This bill includes clauses on future nursing education programs and on collective bargaining.

Provincial Health Minister Bruce Stewart also spoke at the meeting. He mentioned his department's interest in the bill, and offered his aid in presenting it to the government at the next sitting of the provincial legislature.

Changes in nursing education in Canada were discussed in a speech by Sister Mary Felicitas, president of the Canadian Nurses' Association. She also talked on the goals of CNA and of the International Council of Nurses.

ICN Reports And Papers Available From Geneva

Montreal, P.Q. – Reports and papers given at the International Council of Nurses 14th Quadrennial Congress in Montreal will be issued in two publications by ICN before the end of the year.

These may be ordered from ICN headquarters, Box 42, 1211 Geneva 20, Switzerland. There will be a charge for these publications.

CNA Presents Painting To ICN



Ottawa. – ICN headquarters moved to Geneva, Switzerland at the end of July 1966 after 19 years in London, England. At the Canadian Nurses' Association's board of directors' meeting in September 1967 a suggestion was made that CNA present a gift to ICN in honor of the new location. By March 1968, the 10 provinces had contributed $385 toward the gift.

The gift that was chosen is a needle painting worked in silk on a theme of Canada's autumn coloring. Anne-Marie Matte of St. Hyacinthe, Quebec was commissioned to do this work. Sister Felicitas, president of CNA, describes "Le Pont" as unique and artistic. Mlle Matte's paintings hang in Buckingham Palace, the White House, and several European Embassies.

CNA's gift was formally accepted during the ICN Congress in Montreal by Dr. Alice Girard, ICN president. It will hang in the ICN boardroom in Geneva.

ANPEI Donates $225 To ICN Congress

Charlottetown, PEI. – The Association of Nurses of Prince Edward Island donated $225 to assist the 14th Quadrennial Congress of the International Council of Nurses in Montreal, June 22-28.

The gift was announced June 11 in a letter to the Canadian Nurses' Association from Mrs. Vernon Bolger, executive secretary registrar of ANPEI.

Congress News Goes World-Wide

Montreal, P.Q. – The June Congress of the International Council of Nurses received world-wide coverage from the news media and from nurse journalists.

Highlights of sessions and interviews with registrants and speakers were broadcast to all six continents in 11 languages through the International Service of the Canadian Broadcasting Company.

Axel Thogerson, head of CBC Outside Broadcasts, said the Congress was a unique opportunity to gather material on the world of nursing in several languages.

Daily reports in English were sent by the International Service to Europe, Africa, USA, Australasia and the Caribbean. Also, special items with interviews were shipped to Nigeria, Jamaica, Barbados and Trinidad for relay over local stations there.

A special report and round-table discussion was sent in English to 60 overseas stations in USA, the Caribbean area, Africa, Australia, New Zealand, Ceylon, Cyprus, Malta, Malaysia, Singapore, Burma, and Thailand, and to the Canadian Armed Forces Network in Europe.

Daily French-language reports were included in I.S. transmissions to Europe, Africa, Antilles and USA. Special reports were shipped to French-language stations in Africa and Europe.

Daily reports in German were also sent to Europe. And daily reports and interviews were sent to Europe and Latin America in the following languages: Czech, Slovak, Polish, Spanish, Russian, Portuguese, Hungarian, and Ukranian.

More than 40 nursing press, representing journals from as far away as Australia, Ghana, and Sweden, covered the Congress.

To give an idea of Canadian coverage, some 220 special interviews were arranged during the congress for members of the press, radio, and television. The Canadian Press carried stories before and during the Congress to most papers across Canada, and both national television networks featured the event in their news.

SRNA Meets Challenge, President Reports

Saskatoon. – "Nursing in Saskatchewan has been successful in meeting all the challenges thrust upon it by rapid social changes," said Agnes Gunn, president of the Saskatchewan Registered Nurses' Association, speaking at its 52nd annual meeting May 21-23 in Saskatoon.

"Change is always an opportunity to advance and make progress, and those of us who are flexible in mind will welcome new experiences," Miss Gunn continued. She cited as an example the first graduating class of the two-year nursing program at the Institute of Applied Arts and Sciences in Saskatoon this year, a move encouraged by SRNA.

Miss Gunn also noted the achievements of the provincial bargaining committee, which has been responsible for contract negotiations with the Saskatchewan Hospital Association.

Grace Motta, retiring registrar of the Saskatchewan Registered Nurses' Association, reported that the number of registered nurses in the province had increased by 151 to 5,979. Saskatchewan had gained 201 nurses from other provinces, and 94 from other countries, Miss Motta said. Linda Long, advisor to schools of nursing for SRNA, said 150 nurses had enrolled in refresher courses, which are compulsory for nurses wishing to return to practice after an absence of five years.

Miss Long also reported that eight hospital schools of nursing are closing, six after graduating this year's class, and two more next year. The University of Saskatchewan will discontinue its diploma nursing program and retain only the four-year baccalaureate program, Miss Long said.

Keynote speaker at the annual meeting was Margaret F. Myles, speaking on "Modern aspects of obstetrical practice."

Greetings were brought to the meeting by S.L. Buckwold, mayor of Saskatoon, Louise Miner, president-elect of the Canadian Nurses' Association, and Hester Kernan, president of the Canadian Nurses' Foundation.

US Air Force Nurses Discuss Space Age Nursing At ICN Interest Session

Montreal, P.Q. – Perhaps not too many nurses think of themselves as becoming moon mates, but this space age role is nearing reality, at least for some adventurous United States Air Force nurses. Four of these women attended the Congress of the International Council of Nurses June 22-28 where they gave



Major Dorothy Novotny (left) and Capt. C. Corrado, United States Air Force Nurses, participated in a special interest session on space age nursing at the Congress of the International Council of Nurses.

nurses from around the world a many-sided look at the U.S. aerospace program and the important place of the nurse in it.

Col. Florence Deegan, Commander and chief nurse for the military air lift command at Scott Air Force Base in Illinois, traced the U.S. history of aeromedical evacuation of patients, with the help of colored slides. She gave a detailed description of the latest C-9 Nightingale twin-engine jet which can hold 18 litter and 20 ambulatory patients and has room for 40 patients if necessary. Its basic crew consists of two flight nurses and two medical technicians.

Among the C-9's many unique features is a special carrier area for care of the seriously ill or those with contagious diseases; it has a window through which the nurse can watch the patients. All controls are in easy reach of the medical crew. Patient enjoyment, comfort, and convenience are also taken care of with the most modern devices.

Capt. C. Corrado, an aerospace nursing-course graduate, explained the six-week course in aerospace nursing, the longest course of its kind available, given at Brooks Air Force Base in Texas.

Major Dorothy Novotny, an aerospace nursing supervisor, described the 52-week, post-graduate nursing aerospace program conducted at Cape Kennedy, Florida. It is open to U.S. air force nurses with a bachelor's degree in nursing, who are not over 35, are graduates of the six-week flight nursing course, and have been on active duty three years before they apply for this course.

The three areas of study are bioastronautics, the "application of life sciences in support of man in space," occupational health services, and research. Capt. Corrado said that this program is going to be extended to two years. "In the second year the nurse will go out into the field to apply her knowledge."

Improvement In Quality Theme Of NBARN Meeting

Moncton, N.B. – Improvement in the quality of nursing care was the theme of the 53rd annual meeting of the New Brunswick Association of Registered Nurses in Moncton May 28-30.

Irene Leckie, president of NBARN, addressed the meeting on the role of the nurse in assisting the patient in activities he would perform unaided if he had the strength. She urged nurses to establish priorities and goals in planning care for each patient.

"If we believe that the many complex aspects of direct nursing care should be done by qualified nurses, then we need to reorganize our work so that this patient care is given by those who are qualified and not by unqualified personnel," Miss Leckie said. "We will have only ourselves to blame if we find we can no longer gain satisfaction from our work because we are not nurse practitioners."

The second day of the conference was "program day," with the theme PROJECT: P.L.A.N. (Patients – Let's Assess Needs). Huguette LaBelle, director of nursing at the Vanier School of Nursing, Ottawa, was keynote speaker and leader of the program. She placed strong emphasis on the needs of the patients, saying, "We have been serving the needs of the doctor and hospital for too long."

On the final day of the meeting members passed a resolution that the council consider obtaining a nursing service consultant to promote better patient care. During the same session the finance committee outlined a deficit budget for 1969, and it was decided to call a special general meeting before November 30 to discuss an increase in fees to be effective January 1, 1970.

Irene Leckie was reelected president of NBARN at the meeting. First vice-president is Harriet Hayes; second vice-president, Apolline Robichaud; honorary secretary is Margaret MacLachlan; and the past president is Katherine Wright.

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Internationally-Known Nurses Debate Practice Of Nursing At ICN Interest Session

Montreal, P.Q. – Margaret McLean, senior nursing consultant, Hospital Services Division, Department of National Health and Welfare, says that provision of nursing service in the quantity and quality needed is the major problem faced by nurses in the practice of nursing. During an interest session at the 14th Quadrennial Congress of the International Council of Nurses, June 22-28, she made several suggestions how this need can be met. All discussion was based on the fifth World Health Report in Nursing issued in 1966 and accepted by the ICN.

Reward staff for excellence of service and for nursing care rather than for service time, Miss McLean urged. Have the best qualified nurses with leadership ability as the team leader and allow creativity in nursing by reducing the number of "bosses," she suggested.

Nursing assistants have a role to play, Miss McLean believes. They can carry out specific nursing procedures and tasks for the patient, that do not require the judgment of a registered nurse.

"What kind of education can be provided to ensure good nursing?" Ruth White of Australia asked. The WHO report suggests that nursing education move into the field of general education, with curriculum content controlled by nurses and established in a legislative framework.

Nursing education needs to be part of general education if nursing is to meet the changing needs of the future, Miss White said. In the United States 85 percent of health care is provided outside the hospital; in Great Britain it is 95 percent, she pointed out.

Ayodele Tubi of Nigeria reported WHO's suggestions concerning postbasic education. There is a need for postbasic education in every country, but courses should be planned and developed according to the individual need on the national level. Mrs. Tubi said that the aim of these courses should be to teach the nurse how to find the answers, not to know all the answers.

Grace March, inservice education officer for the Ministry of Health in Jamaica, referred to three types of continuing education: formal study leading to a degree; short term study at an advanced level not necessarily referring to a degree; inservice education provided by the professional organization and the employing agency.

Discussion from the floor followed Dr. J.C. Bacala's comments on nursing research. A medical practitioner in Cottsburg, Indiana, he said he had noticed that nursing research consisted of questionnaires for gathering information but really only gathered opinions. Care of the sick is the purpose of research in nursing, Dr. Bacala said, but bedside nursing is seldom researched.

He expressed concern that the more highly educated the nurse, the farther she is from nursing practice. He concurred with Miss McLean that we should reward the bedside nurse financially so that we can accept reports on patients' conditions, from the best qualified observer.

If postgraduate nursing courses were more like medical residency perhaps more nurses with advanced degrees would stay at the bedside, Dr. Bacala suggested. Clinical specialist courses are the most valuable for good bedside nursing, and will bring the nurse back to the bedside, Dr. Bacala believes.



Birgit Tauber, Margaret Parkin, Virginia Henderson, Alice Thompson, and Luther Christman discuss topics related to the effective functioning of libraries in nursing schools and professional associations during a panel presentation at interest sessions during the ICN Congress in Montreal.

Library Issues Discussed By ICN Panelists

Montreal, P.Q. – A small but select group of nurses attended the special interest session on libraries in schools of nursing and in professional associations held during the 14th Quadrennial Congress of the International Council of Nurses June 22-28.

Panelists Luther Christman, dean of the school of nursing, Vanderbilt University, Nashville, Tennessee; Virginia Henderson, director, nursing studies index project, Yale University School of Nursing, New Haven, Connecticut; Margaret L. Parkin, librarian, Canadian Nurses' Association; Birgit Tauber, nursing officer, National Health Service of Denmark, Copenhagen; and Alice Thompson, editor of *International Nursing Review,* Geneva, Switzerland, presented several questions for consideration:

1. What organizational structure within a country might effectively promote library resources, facilities, and services?
2. How can present resources and needs be determined within a given area?
3. Where might nursing look for funds to provide needed library resources?
4. What types of space, equipment, and materials should be considered as comprising library resources for nurses? What are the criteria for acquiring and withdrawing library materials?
5. To what extent are the library needs of nurses different from those in other health professions?
6. Would a library of integrated facilities for several health professions be feasible?
7. What types of library tools are needed in nursing and who should be responsible for them?
8. How can the effective use of library resources be promoted?
9. Who should staff libraries in schools of nursing?

Members of the audience contributed answers to these questions based on their experiences in library work.

Continuity Of Patient Care Discussed By ICN Panelists

Montreal, P.Q. – More than 500 nurses attended a special interest session on the continuity of patient care, held during the 14th Quadrennial Congress of the International Council of Nurses, June 22-28.

Constance Swinton, a nurse with the Victorian Order of Nurses, defined continuity of patient care as "the right care at the right time in the right place." Today, home care is a complex, highly organized institution, Miss Swinton said. In many areas of Canada, a hospital referral program has made it possible for the chronically-ill, the long-term, and the acutely-ill patient to be cared for at home, she reported. This helps to reduce hospital costs, she added.

Good nursing care depends on a nurse's assessment of the patient's pre- and post-hospital care requirements; that necessitates close cooperation between hospital and community, Miss Swinton explained.

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*Kehlmann, W. H.: Mod. Hosp. **84**:104, 1955

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of coordinated home care involving several health disciplines, a panel composed of physician, hospital-based nurse, social worker, physiotherapist, speech therapist, and VON nurses conducted a team conference based on their approach to the home care of a two-year-old boy with mandibular facial dystosis. Panel participants were members of the Montreal Children's Hospital Home Care Program.

The home care program set up for a man and his wife was the basis for a second panel discussion presented by the greater Montreal branch of the Victorian Order of Nurses. Panelists discussed plans made for this couple. The liaison nurse first assessed the patients' suitability for home care – in consultation with the attending physician and the head nurse. The VON nurse who cared for the patients made her assessment and arranged for the assistance of a physiotherapist and a homemaker. During the entire home care program, the team members met regularly to evaluate the patients' progress in preparation for their return to independent living.

Too Much Treatment A Danger Warns ICN Psychiatry Panelist

Montreal, P.Q. – Too comprehensive a nursing program could rob the mental patient of the opportunity to function independently in the modern hospital setting, warned Lorine Besel, chairman of a special interest session on psychiatric nursing at the Quadrennial Congress of the International Council of Nurses in Montreal, June 22-28.

The therapeutic community, said Miss Besel, is a concept in which the whole of the patient's time in hospital is thought of as treatment. This is a sharp change from an earlier view that medication, physical treatments, and an hour with a psychiatrist was treatment. Miss Besel added that an effort must be made to reproduce an environment in which the patient will take as much responsibility as he is able to handle.

Miss Besel also said that nurses' personal conflicts increase their difficulties in dealing with psychiatric patients. Often nurses cannot work within a group setting; they feel inadequate in a group and are not prepared to cope with their own feelings, let alone the patients' feelings, she said.

Authority is another difficult area because the nurse learns to accept a passive role in general nursing, and must learn to be an equal in psychiatric nursing. Team participation and negotiation must also be learned, said Miss Besel.

Miss Besel's opening remarks were followed by panel presentations by Mary Christie, John Greene, Mrs. Noël Robinson, S.M. Bohn, and A.M. Dneppe.

ICN Interest Session Speakers Examine Nursing Legislation

Montreal, P.Q. – Nurses attending a special interest session of the ICN Congress June 26 learned the pitfalls involved in framing nursing legislation from three specialists who have been active in this field in their home countries.

Mary Henry, registrar of the General Nursing Council for England and Wales, outlined fundamental issues in seeking such legislation. First, she said this legislation is the foundation on which the profession must be built if it is to grow in stature. Second, nursing legislation must be framed to meet the needs of the country. It must be realistic and not set its sights too high or too low; the legislation must be capable of implementation. Third, it should be framed so that it does not need frequent revision. With the constantly changing pattern in nursing needs in the community, regulations should not be too detailed, Miss Henry warned, for changes take a long time. She emphasized that the freedom to experiment is essential. Overall change should be gradually introduced and should prove successful before being generally accepted throughout the country, she said.

Both Miss Henry and Laura Barr, executive director of the Registered Nurses' Association of Ontario, stressed the necessity of having social and economic legislation for nurses remain distinct from nursing legislation.

Miss Barr compared nursing legislation, whose focus is on the protection of the public, with socioeconomic legislation, which is highly motivated by the self-interest of the nursing profession. It is difficult to believe that a reasonable balance of interests could be maintained if one piece of legislation were to serve two such distinct purposes, Miss Barr said.

Speaking of the administration of nursing legislation, Miss Barr referred to two points of view – external and internal. The external involves the machinery established within the government to support the legislation it creates.

"In looking at government departments, shouldn't we be assessing each to determine where the greatest expertise lies to help us achieve our goals in nursing?" she asked. She pointed out the opportunity to participate in the administration of nursing legislation should be available to all nurses.

On the other hand, Miss Barr explained, it is customary to administer legislation for socioeconomic welfare through a group of members a majority of whom might be involved in collective bargaining.

The time has come, said Miss Barr, when we must show that the programs we

conduct as associations are influenced more equally by three sources: 1. the individual nurse and her needs that are basic to her being an effective health worker; 2. the profession as a whole; 3. the public we serve.

Julie Symes, registrar of the nursing council in Jamaica, pointed out the importance of lobbying when nurses are seeking legislation. They must explain their need for legislation to all parties and should approach leaders of other groups in the community. Nurses must also study the laws of other countries to guide them, Miss Symes said. She warned that when nursing legislation is drafted, it should be worded so that nurses who are already trained can be registered, and that anything making it too difficult for nurses from abroad to register should be avoided.

Where there is provision for disciplinary action to be taken against nurses, there must be the right of appeal, she said.

ICN Interest Session Debates Role Of Rehabilitation Nurse

Montreal, P.Q. – The role of the rehabilitation nurse in fulfilling the special needs of her patients was discussed at a special interest session at the International Council of Nurses' Congress in June.

Specialists from the Rehabilitation Institute of Montreal outlined their functions in relation to the handicapped patient. After each had spoken, Elizabeth Epp, a nurse from the Institute, discussed the implications of that role for the nurse.

Areas under discussion included physiotherapy, social service, speech therapy, ergotherapy, psychology, and prosthetics.

Dr. Gustave Gingras, director of the Rehabilitation Institute and co-chairman of the session, emphasized that it is vital for the nurse to maintain constant rapport with the specialist.

"It is possible for the nurse and a therapist to work in a complete vacuum," he said, "but I see no reason for an amputee not to walk on weekends because his therapist is off duty."

Miss Epp said the nurse must be aware of the underlying principles and techniques of all the disciplines of rehabilitation. The nurse provides valuable backup work in physiotherapy, she said, by assisting a patient with braces, slings and other aids for ambulation and manipulation. To do this she must know about the care, function, and application of these appliances.

Miss Epp advised the rehabilitation nurse to observe the patient's performance and progress during sessions with the therapist. This will make her more aware of the problems of other patients undergoing the same kind of surgery, she said, and also will aid in the nurse's supervision of the patient on the ward.

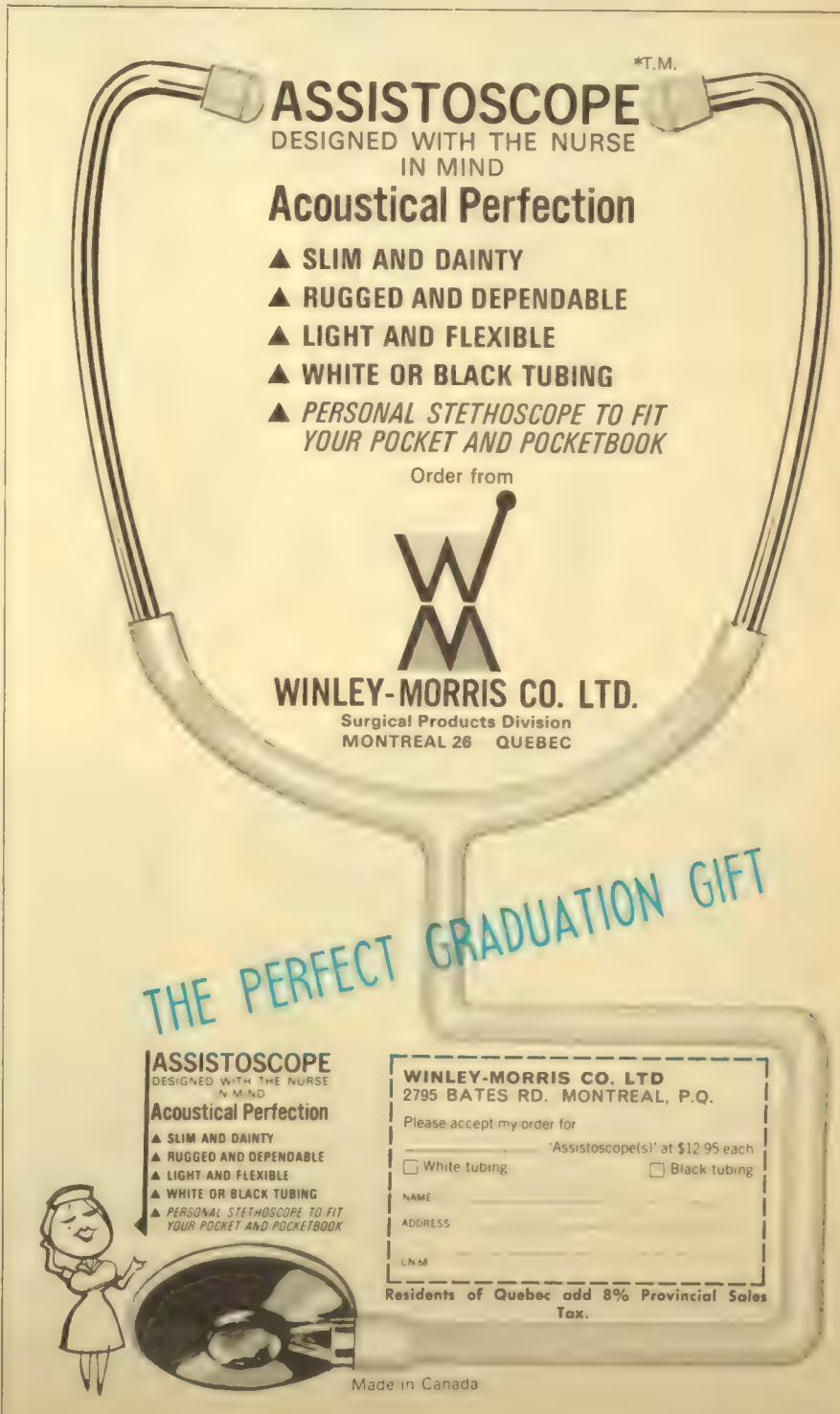
Miss Epp commented on the strong bond of cooperation between nurse and social worker, adding that it provides "a more positive, more productive outlook for the patient, not only with an eye on his residence at the hospital, but with a particular accent on his return to the community."

Chairman of the session was Miss M.B. Whitton, vice-chairman of the Royal College of Nursing and National Council of Nurses of the United Kingdom.

Liberian Government Doubtful Of Family Planning Clinics

Montreal, P.Q. – In Liberia, men, not women, are the obstacle to family planning, said Jeannette King, one of several panelists on the special interest session on outpost nursing at the 14th Quadrennial Congress of the International

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Council of Nurses in Montreal. She said many husbands of women coming to the clinics in her country suspected that their wives simply wanted no more children, rather than that they were planning to space the family for health reasons.

"From top to bottom, the government men opposed giving such advice because they feared a drop in the birthrate," she said. "We agree that we are an unpopulated country, but we had to explain that we favor spacing pregnancies, not cutting the number of children born," she added. She said that it took two years to get government permission to run the clinics.

Miss King was on a panel chaired by Electa MacLennan, director of the school of nursing at Dalhousie University. Panelists included Catherine Keith, Ruth May, Carolyn Banghart, E. Holdgate, Kapelwa Sikota, and Pilar D. Pacifica.

Nurses Reluctant To Write ICN Delegates Told

Montreal, P.Q. – Nurses are unaccustomed to being vocal and therefore are reluctant to write articles, a U.S. educator told about 225 nurses at an interest session on "The Printed Word" at the 14th Quadrennial Congress of the International Council of Nurses.

Responding to a comment from panel chairman Richard Newcombe that it is difficult to get nurses to write articles, Dr. Ruth V. Matheney of the department of nursing at the Borough of Manhattan Community College in New York, said that in the past nurses have refrained from expressing their opinions – verbally or in writing – partly because they have equated criticism with disloyalty. Dr. Matheney said that she doubted that special courses in writing for nursing students would stimulate greater debate.

Other panelists at "The Printed Word" session included Enid Meehan, editor of the *Irish Nurses' Journal;* Gertrude Swaby, secretary of the Jamaica Nurses' Association; Isabel LeBourdais, PR officer, RNAO; Yvonne Cross, editor of *Nursing Mirror and Midwives Journal;* and Gordon Henderson, legal consultant to CNA.

"Design, Then Build," Renowned Consultant Tells CHA

Ottawa. – Define the problem, design facilities for the total concept, be flexible, and don't forget the patient, were ideas presented by Gordon A. Friesen, the well-known hospital consultant, to delegates at the Canadian Hospital Association's second national convention and assembly May 21-23.

Mr. Friesen, president of Gordon A. Friesen International Inc. Washington, D.C., a firm of hospital consultants, held his audience entranced while with gestures and vocal spurs he talked about his concept of the modern hospital.

Twentieth century medicine is practiced in nineteenth century facilities, he said, and hospitals are 25 years old when they open their doors for the first time.

Mr. Friesen urged that better use be made of the health workers we now have. The Kitchener-Waterloo hospital in Ontario gave him the first opportunity to put some of his ideas into practice and his colored slides portrayed effectively many of these. More than 40 hospitals have been designed using Friesen concepts. His concept of central dispatching frees the nurse to nurse. An aide brings supplies for each patient through an outside corridor, and places them in a dispensary accessible from two sides, Mr. Friesen explained. The nurse receives supplies directly into the patient's room.

"Why duplicate facilities? " he asked. "Doctors' offices should be within the hospital." Put the administrative core in the center and build what you need to operate efficiently around it, he said.

One hundred and eighty-four interruptions in a 24-hour period for one patient surely indicate that we need the team approach, Mr. Friesen said. But motivation and inservice education are needed to make it work, he continued.

Patient units should be flexible, converting easily from single rooms to groups of rooms, and from obstetrics to surgery as the need indicates, he advised. On the subject of separate nurseries, Mr. Friesen quipped, "All husbands don't hate their wives, and children their parents."

McGill Student Nurses Contribute To CNF

Montreal, P.Q. – The Graduate Nurses' Students' Society of McGill University has contributed $200 to the Canadian Nurses' Foundation. The money was collected from members during elections for the 1969-70 executive, and forwarded



Isabel LeBourdais, public relations officer for the Registered Nurses' Association of Ontario and editor of *RNAO News,* talks about editorial freedom at a special ICN interest session held at McGill. Chairman Richard Newcomb, editor of *RN* magazine, is at left; Yvonne Cross, editor of the *Nursing Mirror and Midwives Journal,* and Gordon Henderson, legal consultant to the Canadian Nurses' Association, were fellow panelists.



It was standing room only at the special ICN interest session on nursing journalism Tuesday June 24. Panelists included, left to right: Barbara Schutt, editor, *AJN;* Daisy C. Bridges, chairman; Philip E. Day, executive director, American Journal of Nursing Company; Donald Williams, Rapid Grip and Batten – the firm responsible for layout for *The Canadian Nurse;* and Nancy J. Kinross, Health Department, Wellington, New Zealand.

to the Foundation in June.

"We hope that, through our efforts, other students in schools of nursing and universities could be made aware of this fund, and could plan future contributions," said Kathleen Kennedy, president of the Society. "As postbasic students, we recognize the importance of assisting in furthering the education of nurses in Canada," she said.

Despite the interest of student groups, membership in CNF has dropped from 1,482 in September 1968 to 920 in June 1969. A CNF spokesman pointed out that at least part of the drop was due to a changeover in fiscal years. "September was the end of the fiscal year in 1967-68" she said. "We hope that at the end of this fiscal year, in December, that membership will be comparable to last year's." The record high for membership was 1965, when there were 1,697 members.

Breakdown of membership is as follows: British Columbia 99; Alberta 78; Saskatchewan 104; Manitoba 51; Ontario 282; Quebec 66; New Brunswick 143; Nova Scotia 46; Prince Edward Island 4; Newfoundland 8; outside Canada 27; sustaining 11. There is one patron, making a total of 920.

McMaster Student Nurses Request Financial Aid

Hamilton, Ont. – Students of the school of nursing at McMaster University presented a report to Ontario health minister Matthew B. Dymond May 30, requesting that the Ontario government make bursaries available for students in the basic degree program in universities.

The five-page brief included a table comparing the costs to students in the McMaster school with those to students in St. Joseph's Hospital, Hamilton and District Hospitals, and Hamilton Civic Hospitals schools of nursing. Costs were $7,300, $1,210, $1,275, and $990 respectively for the total training period. Pay differential after graduation was $80 per month.

The report pointed out the difficulty in acquiring financial assistance for basic degree program students. Assistance is offered to registered nurses by the Ontario government, but the Victorian Order of Nurses was cited as the major source of aid to basic degree program students. The brief also pointed out that the Canadian Nurses' Association's *Submission to the Royal Commission on Health Services* had suggested that funds be made available for loans to these students, and that the Royal Commission has called the integrated course the only educationally sound one.

ICN Election Results

Elected to office in the International Council of Nurses at the closing session Friday, June 27, were:

President: Margrethe Kruse – executive secretary of the Danish Nurses' Association since 1945.

First Vice-President: Dorothy A. Cornelius – executive director of the Ohio Nurses' Association and President of the American Nurses' Association.

Second Vice-President: Alice Girard –immediate past president of the ICN and dean of the Faculty of Nursing at the University of Montreal.

Third Vice-President: Ruth Elster – president of the German Nurses' Federation.

Board of Directors: Nicole F. Exchaquet, Switzerland; Barbara Fawkes, United Kingdom; Nelly Goffard, Belgium; Mrs. Jadwiga Izycka, Poland; Docia A.N. Kisseih, Ghana; Jane Martin, France; Joyce C. Rodmell, Australia; Julita V. Sotejo, Philippines; Catherine Verbeek, Netherlands; Mrs. Gerd Zetterstrom-Lagervall, Sweden.

Membership Committee: Lyle M. Creelman, Canada; Jo Eleanor Elliott, United States of America; Phyllis Friend, United Kingdom; Mrs. Kofoworola A. Pratt, Nigeria; E. Beatrice Salmon, New Zealand; Olive E. Anstey, Australia; Julie Symes, Jamaica.

Professional Services Committee: Ingrid Hamelin, Finland; Laura W. Barr, Canada; Dr. Rebecca Bergman, Israel; Adele Herwitz, United States of America; Renée de Roulet, Switzerland; Gertrude Swaby, Jamaica; Grace M. Westerbrook, United Kingdom.

Two-Year Program's Discussed At RNANS Annual Meeting

Yarmouth, N.S. – Education was the highlight of the 60th annual meeting of the Registered Nurses' Association of Nova Scotia in Yarmouth, May 27-28.

The 150 nurses attending the meeting heard Sister Ann Gill of the Halifax Infirmary discuss the needs of the graduate of the two-year program, saying that the basic need of such a graduate was an organized inservice program. Sister's talk was followed by a panel discussion on the implications of the two-year program.

This September at least three schools in Nova Scotia will move into the two-year program, and several of the smaller schools will be phased out.

Reports presented at the meeting also noted:

- the annual fee for membership in RNANS has increased from $25 to $35;
- educational requirements for entrance to schools of nursing in the province will be Nova Scotia grade 12;
- the association's bulletin will be published quarterly rather than monthly.

Joan Fox was elected president at the meeting.

Visiting Homemaker Services In Short Supply

Ottawa. – The Canadian Welfare Council hopes to discover why the visiting homemaker service is in short supply. The Council has begun a study of selected homemaker agencies in seven provinces. The study, supported by a grant from the Welfare Grants Division of the Department of National Health and Welfare, is expected to cost over $28,000 and take one year to complete.

Visiting homemaker services are recognized by home economists, nurses, and social workers as a necessary community service for people of all incomes, in time of need.

In Canada there is only one homemaker for every 30,000 persons. Homemaker services in Canada operate under the auspices of family service associations, the Canadian Red Cross Society, the V.O.N., and others.

Areas for study by a committee of the council include: the structure of these agencies and their financing; the recruitment, training, hours of work, duties, and salaries of the homemakers; and the types of families that are served. Policy recommendations will then be formulated in an effort to relieve the shortage of visiting homemakers and meet community needs.

In the past the "extended family" took the place of the visiting homemaker. Today the role of the extended family has dwindled and the visiting homemaker must assume this role.

Interim Executive Director Appointed By ANA

New York, USA. – Hildegard Peplau has been appointed interim executive director of the American Nurses' Association, Dorothy Cornelius, ANA president, announced in July.

Dr. Peplau will assume her duties in September. She is now professor and director of the graduate program in psychiatric nursing at Rutgers, the State University of New Jersey, and will be on leave of absence from Rutgers during her temporary appointment.

She will succeed Judith Whitaker, who has been ANA executive director from 1958 to the present.

Dr. Peplau, who holds a doctor of education degree in curriculum development from Teachers College, Columbia University, has served on many com-

(Continued on page 19)

(Continued from page 19)

mittees and advisory groups of both the ANA and the National League for Nursing. She is currently chairman of ANA's division of psychiatric-mental health practice; a member of the Congress on nursing practice; and she is ANA consultant to the advisory council of the National Institute of Mental Health.

First Licence Granted For Rubella Vaccine

Montreal, P.Q. – The world's first licence for a vaccine to prevent rubella, commonly known as German measles, was granted by Switzerland April 3.

Recherche et Industrie Thérapeutiques (RIT), a Belgian subsidiary of Smith, Kline & French Laboratories, was granted the licence for a vaccine using the live "Cendehill" virus strain, developed by RIT. The Cendehill vaccine, a live attenuated strain of the wild rubella virus, is grown in primary rabbit kidney culture.

Of more than 60,000 persons vaccinated in large-scale studies, 97.5 percent became immune to the disease. A single subcutaneous injection of the Cendehill vaccine provides immunity against rubella. But it will require years of retesting vaccinated persons to determine whether this vaccine or any rubella vaccine gives lifelong immunity.

The studies also showed that the vaccine is well tolerated and attenuated enough that it does not spread the virus from the vaccinates to susceptible unvaccinated persons. Used largely in children, young girls, and adult women the vaccine has caused no significant clinical symptoms and no significant reactions.

The most recent North American epidemic of rubella, a relatively minor disease in children but serious in women during early pregnancy, occurred in 1964-65 when there were some 20,000 birth abnormalities and fetal deaths in the United States alone. Another epidemic is expected in 1970-71.

The vaccine is being reviewed in Canada by the Food and Drug Directorate.

Two Workshops At UWO

London, Ont. – Two seminars on test construction were held for teachers recently at the University of Western Ontario. The workshops, conducted by Vivian Wood, assistant professor of nursing, UWO, were cosponsored by the school of nursing and the extension department of the university.

The workshops consisted of task-oriented work sessions on essay questions, models for marking essays questions, objective examinations and item-writing practice sessions, and final assessment of student nurses.

The first workshop was held May 5-7, and was attended by 28 teachers from Ontario, New Brunswick, and Nova Scotia. The second was held June 15-18, and was attended by 35 teachers from Ontario, British Columbia, Alberta, Quebec, New Brunswick and Nova Scotia. □

An Unlikely Author



Victoria, B.C. – A nurse married to an Armed Forces lawyer, who has raised three children while following her husband through 18 moves in 25 years, would hardly be a likely author of a Doubleday Crime Club choice. But Marion Rippon, the unlikely author, sold *The Hand of Solange* to Doubleday and Company a year ago, and the book will be on sale by September.

"It's a sort of psychological mystery," Mrs. Rippon explained. "The murders and sex aren't very important; it's the psychological process leading up to the murders that I have tried to trace." Experience with mental patients in the Canadian Forces Hospital in Halifax helped her understand the workings of mental patients, she said. The story is set in France, where Mrs. Rippon's husband was posted for four years. It tells the story of Solange, a schizophrenic who is a compulsive eater. "She switches from the world of reality, which is intolerable to her, to her own world of fantasy where she sits and eats chocolate bars," Mrs. Rippon said. "I haven't used any real cases, but I have tried to keep it as authentic as possible. Most of the other characters are perfectly ordinary Frenchmen."

Mrs. Rippon is working on a sequel to her novel – *Behold the Druid Weeps for Thee.* It has also been bought by Doubleday.

names



Glenna Rowsell (R.N., St. John's General H., St. John's, Nfld.; dipl. in clinical supervision, dipl. in nursing education and administration, U. of Toronto; dipl. in Public Health Nursing, U. of Ottawa) leaves the Canadian Nurses' Association in July to become employment relations officer of the New Brunswick Association of Registered Nurses.

Miss Rowsell remained in her native Newfoundland until 1961, as a staff nurse in the operating room, assistant instructor at the General Hospital in St. John's, nursing arts instructor, and finally as associate director of the same school of nursing. In 1961 she joined CNA as director of the association's school improvement program, and in 1966 she became consultant in social and economic welfare.

Miss Rowsell has traveled throughout Canada in her position as consultant. Last October she conducted educational workshops throughout New Brunswick on social and economic welfare, sponsored by the New Brunswick Association of Registered Nurses. In February and March 1969, she conducted workshops on collective bargaining in Manitoba.



Dorothy S. Starr (B.A., Simpson College, Iowa; M.N., Yale U. School of Nursing, New Haven, Conn.) left her post as principal of the Ottawa Civic Hospital school of nursing in July.

Mrs. Starr began her experience in the Lord Dufferin Hospital in Orangeville, Ontario, then joined the psychiatric unit of the Institute of Human Relations at Yale University as a staff nurse. A year in Pakistan with the American Friends Service Committee followed, during which she served as a "nurse-of-all-trades" with the Quaker mobile medical team. She then joined the Ottawa Civic Hospital school of nursing, first as a teacher, later becoming administrative assistant, assistant director, and principal of the school.

Mrs. Starr leaves to become assistant professor of nursing at Ottawa University.

New ICN Executive



The Council of National Representatives elected a new executive for the next quadrennium during the Congress of the International Council of Nurses in Montreal June 22-28. From left to right are Ruth Elster, Germany, third vice-president; Alice Girard, Canada, second vice-president; Dorothy Cornelius, United States, first vice-president; and Margrethe Kruse, Denmark, president, wearing the Presidential Chain of Office.

Miss Kruse has just completed four years as chairman of ICN's Professional Services Committee, a position in which her knowledge of social and economic welfare was very important. She has been executive secretary of the Danish Nurses Association since 1945.

At a press conference held following the announcement of her election as ICN president, Miss Kruse said she hoped ICN would remain non-political. "We can't interfere with the political systems of countries," she said, answering a question about countries that practice racial discrimination. "We must show that we can live in peace and love each other."

Dorothy Cornelius is executive director of the Ohio Nurses' Association and president of the American Nurses' Association. She has been president of the American Journal of Nursing Company and chairman of her national association's employee relations committee.

Alice Girard, immediate past president of the ICN, is dean of the faculty of nursing at the University of Montreal. Dr. Girard is a member of the World Health Organization's Expert Committee on Nursing. She is a past president of the Canadian Nurses' Association and the Canadian Nurses' Foundation.

Ruth Elster, who was second vice-president of ICN in the past quadrennium, has been president of the German Nurses' Federation and the Agnes Karll Association, one of the federation's member associations, since 1957. She has served on the ICN Finance and Administration, and Economic and Welfare Committees. Miss Elster is a member of the WHO Expert Advisory Panel on Nursing.

names

Laura W. Barr, executive director of the Registered Nurses' Association of Ontario since 1961, was elected to the seven-member Professional Services Committee at the Congress of the International Council of Nurses in Montreal. Miss Barr was a member of this committee during the past ICN quadrennium.

During the time she has been executive director of the RNAO, active programs have been developed in all fields relating to the welfare of nurses.

At the ICN Congress, Miss Barr was one of three panel members at a special interest session on nursing legislation (see News, p.16).



Nora Paton (Reg.N., Toronto General H.; Dipl. in Neurological and Neurosurgical Nursing, Montreal Neurological Institute; B.N., McGill U.) has been appointed director of personnel services for the Registered Nurses' Association of British Columbia. She joins RNABC on a half-time basis in September, and in June 1970 will take over this position from Evelyn E. Hood, who is retiring.

Miss Paton is studying toward a master's degree in education at the University of British Columbia.

Miss Paton left The Vancouver General Hospital in May, after nine years as a general duty nurse and head nurse of the neurosurgical unit. She has done general duty nursing at St. Luke's Hospital in Denver, Colorado, and the Montreal Neurological Institute, where she became director of nursing education.

Eight former Saskatchewan nurses were awarded honorary memberships in the Saskatchewan Registered Nurses' Association at the 52nd annual meeting in Saskatoon, May 21-23: They are:

Margaret F. Myles; the well-known author of *A Textbook for Midwives,* is a graduate of Yorkton Union Hospital School of Nursing, and was director of nursing there from 1928 to 1931. **Audrey M. Shattuck** was director of nursing at Meadow Lake Union Hospital from 1959 to 1967, and was active in SRNA. **Sister Armande Ste-Croix** was director of nursing of St. Paul's Hospital, Saskatoon, from 1942 to 1955, and supervisor of the obstetrical unit from 1965 to 1967.

Mary Elizabeth Keyes was director of nursing at Maple Creek Union Hospital from 1951 to 1967. **Elizabeth H. Mitchell** formed the first SRNA chapter in Weyburn and was its first president. She has held several positions at Weyburn Union Hospital. **Alberta Normandin** does relief work at Buffalo Narrows Outpost Hospital. She has also done relief nursing at Sandy Bay Outpost Hospital, and was public health nurse, supervisor, then officer in charge of medical health for the Assiniboia-Gravelbourg health region from 1935 until 1966.

Kate Chapman of Saskatoon has been president, secretary, and chairman of several committees of the Humboldt Chapter of SRNA. **Jean S. Harry** was director of nursing at Winnipeg General Hospital, Victoria Union Hospital, Prince Albert, from 1933 to 1959.



Edith G. Stevenson (R.N., Butler H., Providence, Rhode Island; Certificate Public Health Nursing, U. Toronto) has retired as a nursing counselor with the Ottawa Branch of Medical Services, Department of National Health and Welfare. Miss Stevenson held this position for 20 years.

Before she joined the government, Miss Stevenson worked with the Victorian Order of Nurses in Montreal, North Bay, and Preston, Ontario.



Hazel B. Keeler (R.N., The Vancouver General H.; dipl. in teaching and supervision, School for Graduate Nurses, McGill U.; B.A., U. of Saskatchewan; M.A., Teachers College, Columbia U.) is retiring as director of the school of nursing at the University of Saskatchewan.

Miss Keeler began nursing as an obstetrical supervisor at the Kootenay Lake General Hospital, Nelson, British Columbia. She has held the positions of clinical supervisor at the University of Alberta Hospital in Edmonton, associate professor of nursing education at the University of Buffalo, director of nurses at the Women's College Hospital in Toronto, and science instructor at The Vancouver General Hospital. She was the organizer and first director of the department of nursing education at the University of Manitoba.

Miss Keeler became director of the school of nursing at the University of Saskatchewan in 1950. She reorganized the work in the school to provide for specialized training in public health nursing in the five-year degree course.

Also active in the Canadian Nurses' Association, Miss Keeler served as a vice-president and chairman of the CNA committee on nursing education.



Karen Walker (Reg.N., Victoria H., London, Ont.; Dipl. Psych. Nursing, Allan Memorial Institute, Montreal; B.Sc.N., U. Western Ontario) has been appointed assistant director of nursing education at the Clarke Institute of Psychiatry in Toronto.

Prior to her appointment, Mrs. Walker was an instructor at the Clarke Institute — a University of Toronto teaching hospital and research center.

For the past two years she has been a member of the Toronto-Hamilton area educators in psychiatric nursing.

Two New Brunswick nurses were honored at the 53rd annual meeting of the New Brunswick Association of Registered Nurses in Moncton, May 28-30.

Lois Smith, formerly director of nursing at the Provincial Hospital in Saint John, and **M. Jane Stephenson,** formerly director of nursing at the Saint John General Hospital, were awarded honorary membership in NBARN at the annual banquet. The memberships were presented in recognition of long and outstanding service to the Association.



Marilyn Barras (Reg.N., St. Joseph's H., Toronto; B.Sc.N., U. of Western Ontario; postgraduate course in pediatric nursing, Washington Children's Hospital, Washington, D.C.) has been appointed director of nursing, Humber College of Applied Arts and Technology in Toronto.

Mrs. Barras spent one year as an assistant nursing arts teacher, four years as a pediatric nursing teacher, and two years as nursing education coordinator at St. Joseph's school of nursing in Toronto.

Honorary memberships were awarded to two nurses at the annual meeting of the Registered Nurses' Association of Nova Scotia in Yarmouth, May 27-28. **E.A. Electa MacLennan**, director of Dalhousie University school of nursing, and **Hope Mack**, director of nursing at the Nova Scotia Sanatorium, Kentville, N.S., were honored by the 150 nurses attending the meeting. □

dates

September 17-19, 1969
Annual Convention, Alberta Certified Nursing Aide Association, Calgary, Alberta.

September 18-20, 1969
Annual conference on obstetrics, gynecologic, and neonatal nursing, Sheraton-Brock Hotel, Niagara Falls, Ontario. Sponsored by District V of the American College of Obstetricians and Gynecologists.

September 22-24, 1969
Annual Convention, Alberta Medical Association, Calgary, Alberta.

September 23-25, 1969
10th annual meeting and convention of Associated Nursing Homes, Inc., Sheraton-Connaught Hotel, Hamilton, Ont.

September 25-27, 1969
3rd annual postgraduate course for emergency room nurses, Palmer House Hotel, Chicago. Tuition fee: $60. Write to: Dr. Anast, 55 East Washington Street, Chicago, Illinois 60602.

September 28 - October 3, 1969
13th annual Registered Nurses' Association of Ontario Conference on Personal Growth and Group Achievement, Delawana Inn, Honey Harbour, Ont.

October 6-8, 1969
Annual nurses' convention, sponsored by the American College of Obstetricians and Gynecologists, Marlborough Hotel, Winnipeg. For further information write to: Mrs. Jordan, c/o Women's Pavilion, Winnipeg General Hospital 700 William Avenue, Winnipeg 3, Man.

October 9-10, 1969
Annual Convention, Catholic Hospital Conference of Alberta, Edmonton, Alberta.

October 16-17, 1969
Continuing Nursing Education Course in Nursing the Adult with Long Term Illness. The University of British Columbia, School of Nursing, Vancouver, B.C.

October 24, 1969
Catholic Hospital Conference of Ontario Nursing Committee meeting, Westbury Hotel, Toronto.

October 25-26, 1969
Catholic Hospital Conference of Ontario, annual convention, Westbury Hotel, Toronto, Ontario.

October 9-10, 1969
Ontario Hospital Association, 45th annual convention, Royal York Hotel, Toronto.

October 30-31, 1969
Continuing Nursing Education Course in Pediatric Nursing. The University of British Columbia, School of Nursing, Vancouver B.C.

October 2-9, 1969
Second symposium on the use of computers in clinical medicine, Executive Motel, Buffalo, N.Y. Workshops include "The Nurse in a Computerized Hospital Information System." A Canadian workshop is under consideration. For more information write to: Continuing Medical Education, State University of New York at Buffalo, 2211 Main St., Buffalo, N.Y. 14214.

October 6-31, 1969
Advanced program in Health Services Organization and Administration, University of Toronto School of Hygiene. This is the first of two parts of the course. Fee: $200 for each part. Write to: Dr. R.D. Barron, Secretary, School of Hygiene, University of Toronto, Toronto 5, Ont.

November 11-13, 1969
Quebec Operating Room Nurses' Group, annual convention, Skyline Hotel, Montreal.

November 13-14, 1969
Continuing Nursing Education Course in Nursing the Adult with Acute Illness. The University of British Columbia, School of Nursing, Vancouver, B.C.

November 17-21, 1969
World Mental Health Assembly, sponsored by the World Federation for Mental Health and the National Association for Mental Health, Washington, D.C. Theme: Mental Health In The Community. Write to: Dr. Paul V. Lemkau, Chairman, World Mental Health Assembly, 615 N. Wolfe St., Baltimore, Md. 21205, USA.

November 19-21, 1969
Second Manitoba Health conference, Fort Garry Hotel, Winnipeg. This was formerly the Manitoba Hospital and Nursing Conference.

November 24-27, 1969
Conference for directors of nursing, Toronto. Sponsored by Ontario Hospital Association and Registered Nurses' Association of Ontario. □

Next Month in

The Canadian Nurse

- professional nursing associations – are they coming or going?
- a look at inservice in a school of nursing
- film crews at work



Photo credits for August 1969

Gazette Photo Service, Montreal, pp. 10, 12

Malak, Ottawa, p. 7

Julien LeBourdais, Toronto, pp. 8, 10, 14, 18, 21, 30-38

new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.



Infant Immobilizing Board

The new infant immobilizing board has Velfoam covering and Velcro restraining bands. Padded for comfort, the infant immobilizing board permits well-positioned x-rays without holding the child.

Also useful for venesection, exchange transfusion, or umbilical vessel catheterization, the 14" by 23" board, made in Canada, will fit most incubators and will withstand autoclaving.

For more information contact: Down Bros. and Mayer and Phelps Ltd., 261 Davenport Road, Toronto 5, Ontario.

Net-Back Mitt

This mitt is designed with a rigid palm to prevent the patient from using his fingers for grasping himself or other objects. The reach of the patient can be limited further by attaching the extra strap provided to the bed spring or rail. The mitt can also be worn without this strap.

The mitt is constructed of long-wearing nylon, and is available in small, medium and large sizes.

For more information on this Posey product, write to: Enns & Gilmore Limited, 1033 Rangeview Road, Port Credit, Ont.



Duatrol Antacid

Duatrol, a new antacid/antiflatulent, provides buffering action, acid-consuming effectiveness, and relief from gas. It combines three antacid ingredients (calcium carbonate, aluminum hydroxide, and glycine) with the antiflatulent dimethylpolysiloxane.

Formulated to relieve both hyperacidity and the discomfort caused by excess gas in the gastrointestinal tract, Duatrol is recommended for the effective treatment and relief of symptoms of peptic ulcers, gastritis, hyperacidity and those gastrointestinal disorders accompanied by excessive gas.

Duatrol is available as a suspension in 12 fl. oz. bottles, and as monogrammed tablets, strip-packed in boxes of 50.

For further information, write to: Smith Kline & French, Montreal 379, Quebec.

Electrosurgical Handle

This new electrosurgical handle allows quicker, simpler changing of electrodes.

The Model 779 handle uses a new chuck design that eliminates threads and the problems caused by jamming threads. Insertion and removal of electrodes is almost instantaneous. The handle is made of a durable, high-dielectric material that sterilizes well by any method; the unit disassembles quickly into four pieces. For easy handling, the power cord swivels and also enters the handle at a right angle.

For full details, write Gene Lamb, The Birtcher Corporation, Medical Division, 4371 Valley Blvd., Los Angeles, California 90032.

Rubber Implant

Silastic finger joints are designed for metacarpophalangeal and proximal interphalangeal joint arthroplasty. The implant functions as an interpositional material, helping to maintain normal joint relationship. The intramedullary stem and flexible hingelike construction provide normal joint alignment, good lateral stability, and a minimum restriction of flexion-extension.

The intramedullary implants are made of a heat vulcanized medical grade silicone elastomer. Test joints have been flexed more than 45 million repetitions without breaking, indicating that the elastomeric material possesses excellent flex characteristics. The implant is unlikely to cause necrosis or stimulate bone absorption and can be trimmed and shaped to some degree at surgery. Because of this combination of properties, the prosthesis is expected to last the lifetime of a patient.



For further information write: Medical Products, Dow Corning Silicones, Downsview, Ontario. □



when teen-agers want to know about menstruation one picture may be worth a thousand words

Never are youngsters more aware of their own anatomy than when they begin to notice the changes of adolescence. And never are they more susceptible to misinformation from their friends and schoolmates.

To negate half-truths, give teen-agers the facts — using illustrations from charts like the one pictured above. They'll help answer teen-agers' questions about anatomy and physiology. These 8½" x 11" colored charts of the female reproductive system were prepared by R. L. Dickinson, M.D. and are supplied free by Canadian Tampax Corporation Ltd. Laminated in plastic for permanence, they are suitable for grease pencil marking. And to answer their social questions on menstruation, we also offer two booklets — one for beginning menstruants and one for older girls — that you may order in quantities for distribution.

Tampax tampons are a convenient — and hygienic — answer to the problem of menstrual protection. They're convenient to carry, to insert, to wear, and to dispose of. By preventing menstrual discharge from exposure to air, Tampax tampons prevent the embarrassment due to menstrual odor. Worn internally, they cause none of the irritation and chafing associated with perineal pads.

Tampax tampons are available in Junior, Regular and Super absorbencies, with explicit directions for insertion enclosed in each package.

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Please send free a set of the Dickinson charts, copies of the two booklets, a postcard for easy reordering and samples of Tampax tampons.

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in a capsule

Maple leaves from Japan

One generous donation for the ICN Congress that the Canadian Nurses' Association received from a provincial nurses' association was a gift of 10,000 souvenir-size Canadian flags.

What better reminder of Canada, along with Whoo-fur, could foreign nurses take home from Montreal?

We hear that a slight problem faced the donors before they could present these *Canadian* souvenirs, however. How do you erase "Made in Japan" when it is carved on the wooden stick that holds the maple leaf?

Hire a Canadian Indian to carve around the problem?

Alive and kicking

"What's this man's name – Hitler?" was the stormy reaction of one 83-year-old. "The doctor clearly is not old enough to know better," said the 96-year-old philosopher Bertrand Russell.

These were two of the reactions to the suggestion by British doctor Kenneth Vickery that an age be set beyond which doctors should no longer strive to keep patients alive. "About 80," was his guess at the right time to allow a person to die.

Dr. Vickers said that elderly persons are demanding so much attention that younger persons were no longer getting the attention they needed. He said he realized that euthanasia is unthinkable in a Christian society, but the question could no longer be ignored in a society with insufficient nurses and hospital beds.

Ernest Melling, general secretary of the National Federation of Old Age Pensioners and author of the comment above, said bluntly that he had no faith in doctors. "Who does this man think he is to decide on life and death?"

Dr. Robert McClure, moderator of the United Church of Canada, said "The answer is obvious: get more beds. A nation that can afford its whiskey and beer should be able to afford more beds."

Timeless valley

The Horner Newsletter has a brief report on the Vilcabamba Valley in Ecuador in the June 9 issue. Census figures show that many persons living in the valley, at an altitude of 4,500 feet, live to the age of 130. About 10,000 people live a quiet, rustic existence, with heart ailments non-existent in the 628 persons interviewed by investigators. Other ailments were rare as well. Title of the item: Valley of the Elderly Dolls.



"I think this nursing shortage is overrated, don't you?"

A wardrobe of artificial limbs

An entire wardrobe of artificial limbs might be the answer to the problem of realistic-looking, but inefficient artificial limbs, according to a Scottish bioengineer. Robert M. Kenedi, director of research for the bioengineering unit of the University of Glasgow, said there was little difference between modern artificial limbs and limbs designed in the sixteenth century. Old and modern limbs both were designed to look natural, and therefore have severe limitations because they do not have the normal muscle movements.

Professor Kenedi said that he has always felt that one of the major aspects of rehabilitation should be to overcome disability by giving supranatural ability. But when he asked a group of amputees to accept a highly functional limb, such as a telescopic leg, the response was a little uncertain. Most said they would wear such a device for working conditions, but when they took their wives out for an evening they wanted to look natural.

"So why not a wardrobe of limbs?" asks Professor Kenedi.

"There's a song in my heart"

So, at least, was the situation recently at a hospital in Leicester, England during a delicate heart operation. As the pacemaker machine was switched on, thumping rock and roll music poured out, picked up from a local radio station 400 yards away. Plugs were pulled out to silence the din and surgery continued without the pacemaker. The patient survived. An investigation is now under way in Britain of all hospitals where radio interference might occur. – From *The Horner Newsletter*, volume 6, number 12.

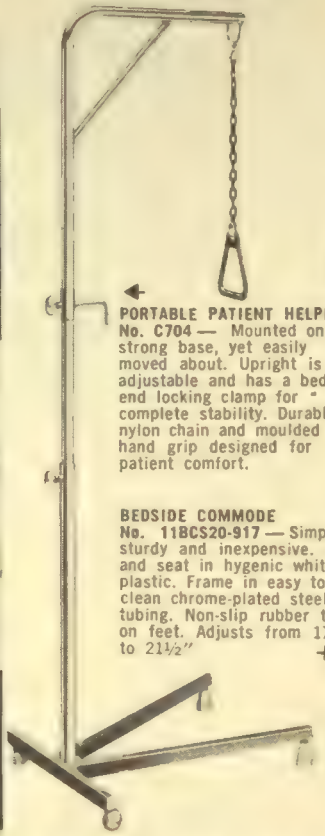
The focal point

Concordia Hall was the scene of many interesting events during the International Council of Nurses Congress in June, but we disagree strongly with the opinion given in the report of the Congress Arrangements Committee. "The fecal point" it was not. □

EVEREST & JENNINGS
Aids to Independence

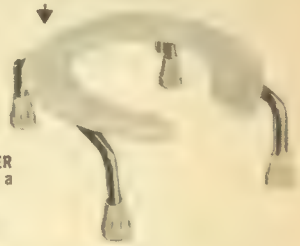


ALUMINUM LIGHTWEIGHT WALKING AID No. C435NA — Balanced design, sound construction and non-slip rubber tips assures strength and stability. Standard model as illustrated, 33" high. Adjustable model, from 33" to 37".

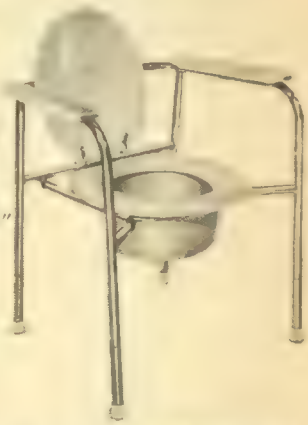


PORTABLE PATIENT HELPER No. C704 — Mounted on a strong base, yet easily moved about. Upright is adjustable and has a bed end locking clamp for complete stability. Durable nylon chain and moulded hand grip designed for patient comfort.

SAFETY GRIP BATH SEAT No. C409 — Elevation of seat permits personal washing in bath tub. Constructed of chrome-plated tubing and fitted with non-slip rubber tips for extra safety. 6" high; width at base 14"



BEDSIDE COMMODE No. 11BCS20-917 — Simple, sturdy and inexpensive. Lid and seat in hygenic white plastic. Frame in easy to clean chrome-plated steel tubing. Non-slip rubber tips on feet. Adjusts from 17½" to 21½"





PREMIER RAISED TOILET SEAT No. C404 — Increases toilet height by approx. 5½". Easily installed and fits all standard toilets. Chrome-plated brackets fix seat to bowl. Seat has matching white plastic sanitary shield.



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With more than 30 years experience in the design and manufacture of wheelchairs, Everest & Jennings now offers a complete range of equipment for the physically disabled. Every item is carefully designed and thoroughly tested for maximum patient satisfaction. Only a few items are shown here. Ask for more details on our full line of AIDS TO INDEPENDENCE.



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It has been said that the measure of truly effective background music is the degree to which it goes unnoticed.

A contradiction? Perhaps. Yet, consider how little thought you give to *anything* while it is fulfilling its functional obligations smoothly. An electric shaver. A radio. A lawn mower. Even the ubiquitous light bulb.

We like to think that our hospital specialty products are somewhat in the background of your professional activities, and also go unnoticed. For experience has shown that when a surgeon is very much aware of the materials with which he is working, something is not working right. And this is the kind of awareness we *don't* want.

It's just one of the reasons we have been striving for over 60 years to produce sutures, needles, and a variety of other surgical products that perform the way you want them to—and striving as well to anticipate the rush of progress in surgery through creative research and innovation.

Along with you, we think that patients should be subjected to the least trauma possible under the circumstances, and be afforded every possible opportunity for successful recovery.

So the next time the untoward behaviour of a product causes you to look twice at the package, look carefully. It probably won't say DAVIS & GECK. That time, incidentally, might be an ideal time to call us. You'll discover that DAVIS & GECK can provide you with products and services that perform so well you'll hardly notice them.

Even if you feel there's an area in which we can improve, please don't wait for us to call you—write us or call collect.

We may not want to be noticed, but neither do we want to be ignored.

ATRAUMATIC® Needled sutures • predictably absorbed Gut suture • silicone-treated Silk suture • braided Dacron* and TYCRON® sutures • DERMALON® nylon suture • Linear Polyethylene suture • Cotton suture • FLEXON® multistrand Stainless Steel suture • PRE-OP® disposable surgical scrub sponge • VIRO-TEC® disinfectant / deodorant spray • FLEXITONE® surgical binders • OWENS* surgical dressings • AUREOMYCIN® dressings •

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Team work: the way to play the game

Frances Howard, B.N.

Radical changes in health care in our society and the rapidity with which these changes are occurring leave the nursing profession only one course of action, if it is to keep apace: it must, through its members and in cooperation with other health disciplines, reexamine and redefine its role. In addition, its members must decide what their functions should be and how they wish "to play the game."

Are we, as nurses, to manage "things"? Are we to act as pseudo doctors? Or are we to practice nursing? I believe there is little argument that our prime purpose is to give nursing care as we ourselves have described it at our professional associations.

Have we been playing the game as we have described it? Probably not, if we are to believe the many criticisms about nursing that abound, both from within and without the profession.

Within the profession we admit that a shortage of personnel has forced us to delegate a large part of nursing care to less qualified persons; we admit, too, that the auxiliaries giving this care are not receiving adequate guidance and supervision; and we admit that the best practitioners of nursing often leave the patient's bedside, because they are promoted to administrative positions, where management of "things" has somehow achieved a higher status than management of "care."

Outside the profession, the criticisms are similar, although often a little more bitter. Probably the complaint most frequently voiced by the patient is that his care is so fragmented that he seldom knows who his nurse is or from whom he can seek advice, information, comfort, and support.

I believe that nurses are both willing and able to give good nursing care. Where, then, does the fault lie? *In the system, or the means by which the functions of nursing is carried out.* How do we improve the system? By adopting the team method of nursing.

Why team nursing?

Success, satisfaction, and reward are dependent on the degree of judgment and decision allowed the practicing nurse. Yet our present system of organization has vested such responsibilities in those persons holding administrative and supervisory positions. The nurse who gives direct patient care has responsibility only for carrying out functions assigned by someone higher up the ladder.

Nursing students are being prepared to give patient-centered care. Regrettably, the work environment tends to decrease initiative and motivation to the point where competency either reaches a plateau or is diminished. Too often the individual adopts the "if you can't beat them, join them" attitude.

Organizations for nursing service should be based on human behavioral principles that recognize both patient and nurse as human beings. Team nursing was designed for this purpose: it is a reorganization of nursing service by which people (nurses) work with and through other people (nurses and patients) to give nursing care.

The primary concern of the nursing team is what is best for the patient. The capabilities of all members of the team are used to their fullest to provide the best possible care. Thus the maximum number of patients benefit from the most skilled care. Moreover, the responsibility for planning and giving nursing care is decentralized and, for the most part, rests with the nurse who is caring for the patient.

Team members have the advantage of immediate supervision and guidance. Face-to-face communication is enhanced, thus increasing the probability of the patient receiving the care he requires. Team nursing encourages individual initiative in the planning and giving of care. Also, a system of checks and controls inherent in team nursing allows the team collectively to establish goals and evaluate the care given.

There is better opportunity, too, to provide continuity of care. Although individual members may be absent, the team, as a group, know and understand the patient and his needs; the patient, in turn, knows "his" team and has confidence in its members.

The hub of nursing

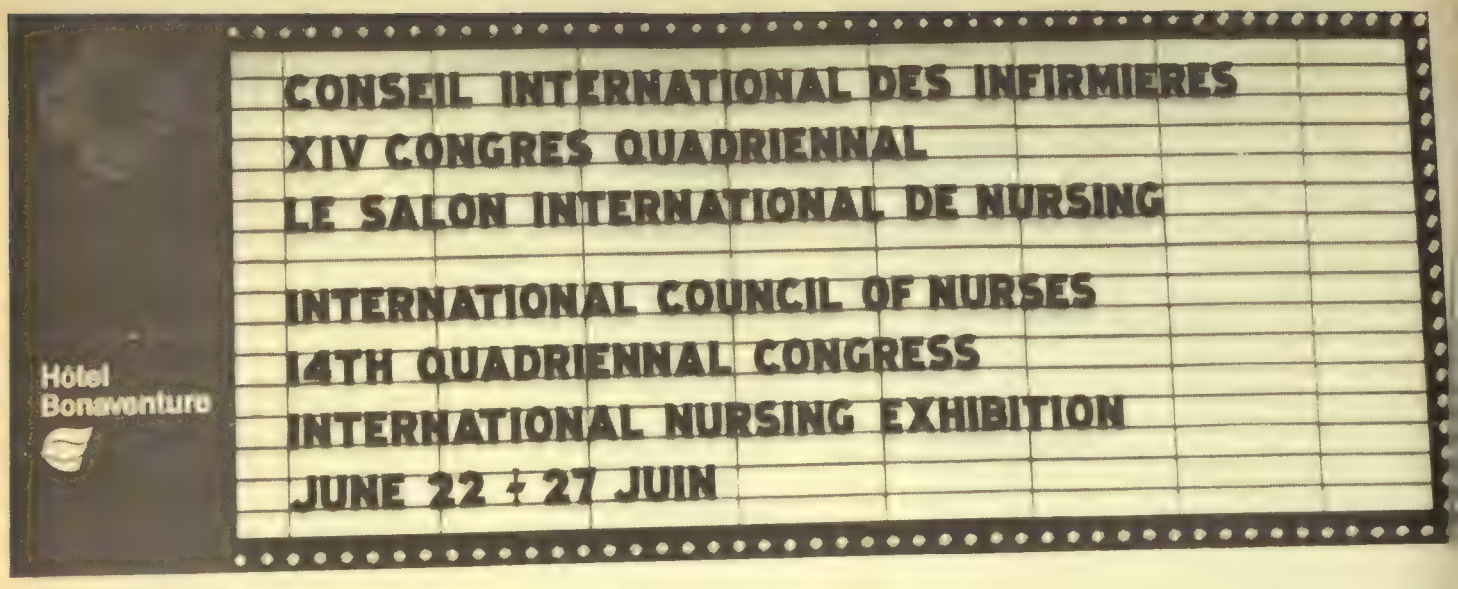
It has recently been suggested that the average organization is designed "to minimize the opportunity for participants at the lower level to perform work from which they can experience a sense of challenge, a meaningful contribution, control over work activities, and opportunities to make decisions count."* Team nursing is a cure for such an illness. When in operation, it becomes the hub around which all supporting spokes are joined. Yet, after more than 20 years, its effectiveness is still being questioned.

Three reasons probably can be found for this neglect of team nursing: 1. lack of planning for change; 2. lack of preparation of personnel for change; and 3. inappropriate supporting structures. If team nursing is to be successful, all personnel must accept the method. Nursing staff should be prepared through staff development programs to function in their new roles. Team nursing is a clinically-oriented system and, therefore, requires a clinically-oriented supporting structure. Too often team nursing has been superimposed on a structure defined around the work to be done, rather than on the patient, his needs, and his problems.

Team nursing is the answer to the nurse's desire to return to her original role of providing nursing care. It also provides the nucleus for a more clinically-oriented organizational structure. In effect, team nursing is the most satisfactory and satisfying way – for both patients and staff – to play the game.

Miss Howard, a graduate of St. John General Hospital, St. John, N.B., the University of Toronto School of Nursing, and the School for Graduate Nurses, McGill University, is Consultant in Nursing Service, Canadian Nurses' Association, Ottawa. Miss Howard leaves CNA next month to begin work toward her M.Sc.N. degree at the University of Western Ontario in London, Ontario.

*Chris Argyris, Organizational illness: an analysis, Toronto, Canadian Imperial Bank of Commerce, Commercial Letter, October, 1968.



ICN CONGRESS REPORT

For a week in June, Canada was the center of the world of nursing. Ten thousand nurses from 85 countries met in Place Bonaventure in Montreal June 22 to 27 to deliberate on both unique and common concerns of nurses and nursing at the 14th Quadrennial Congress of the International Council of Nurses.

A nurse was still a nurse that week in Montreal; however, instead of being identified by a cap and uniform, she was known by the white "Whoo-fur" she wore on her lapel and the special blue-and-white ICN tote bag she carried. Whoo-fur, the furry mascot of the congress, was the Canadian Nurses' Association's gift to every registrant.

Language differences proved no barrier at either the formal or informal sessions. Although English is the official language of ICN, simultaneous translation was provided for all major sessions into French, German, and Spanish. As well, hostesses were on hand to give assistance to those who spoke no English. The hostesses were easily recognized in their white dresses with colorful ribbon sashes designating by color the languages they spoke: green for French, yellow – Spanish; red – German; and blue – English.

When nurse met nurse over coffee, sign language often served as a fifth language. Another aid to communication was the *ICN Bulletin,* published daily in the four languages.

Music, the universal language, was also part of the congress. The red-jacketed members of the Royal Canadian Mounted Police Band entertained a large audience on Monday evening. Wednesday evening, the Montreal Symphony Orchestra presented a special congress concert – a gift of the Province of Quebec – featuring combined selections from composers of many nations.

"Man and His World" – the grandson of Expo 67 – helped to perpetuate the international flavor. A pass was given by the CNA to any nurse wishing to visit the fair, and special trips were arranged on the Saturday following the congress.

The swinging success of the congress represented a personal success for Canadian nurses: the time, effort, and money spent at the local, provincial, and national levels paid off in an exciting event in which all Canadians could take pride.

Opening Ceremonies

The first official function of the Congress was an interfaith service held on Sunday afternoon. Montreal's 140-year-old Notre-Dame Church opened its doors to more than 5,000 nurses and friends. Three ethnic groups provided music for meditation prior to the service, which was conducted by representatives from Hindu, Buddhist, Jewish, Moslem, and Christian faiths.

The address was given by Archbishop Paul Gregoire of Montreal, who said that the service of many denominations helps us to rise above our differences – progress is only possible by acting together.

For the occasion, a responsive prayer and the recessional hymn were spoken in four languages. Father François DeRuijte of St. Joseph Convent, Father Robert Vachon, and Father Jacques Langlais of Monchainin Center, Montreal, created the words.

In honor of Montreal's first nurse Jeanne Mance, ICN president Alice Girard and Goldie Green, representing the Association of Nurses of the Province of Quebec which arranged the service, placed flowers at a stained glass window to commemorate nursing's contributions to mankind.

Varicolored sights and sounds distinguished Sunday evening's formal opening ceremonies of the ICN 14th Quadrennial Congress. Thousands of nurses – many dressed in elegant national costume – watched the dignified, colorful processions of observer associations, ICN board of directors and committee chairmen, ICN Council of National Representatives (CNR), and presidential procession make their way to the revolving stage in the center of the vast Concordia Hall. The flag of each country represented was carried by a Canadian student nurse.

In her welcome, ICN president Alice Girard spoke of the many values of an ICN Congress. "I believe that nothing has yet been found to replace the warm feeling of a spontaneous handshake, the pleasure of watching someone's face light up with interest when captivated by a good speaker, and above all the bond of

friendship that often starts with a friendly smile," she said.

The Governor General of Canada, The Right Honourable Roland Michener, declared the congress and meeting of the Council of National Representatives officially open.

The roll call of the 63 ICN member associations, 58 of whom were present, climaxed a ceremony that brought together what Sheila Quinn, ICN executive director, had earlier called a "huge international family."

Business Sessions

Business of the Congress actually started in closed session of the CNR on Saturday, June 20. During that time, financial reports and details that were not considered to be of general interest to the thousands of nurses at the six-day congress were discussed. CNR is the voting body of ICN and is composed of the president of each national association in membership with ICN.

The first open session of the CNR began Monday morning in Concordia Hall of Place Bonaventure. About 5,000 nurses observed this first business session.

"I doubt whether ICN can go on much longer without drastic changes and still be fulfilling worthwhile goals and objectives," Alice Girard, president of ICN and chairman of the board of directors, said in her report to the CNR. "What are the strengths of ICN, what are its weaknesses? " she continued. "Is it attempting to provide assistance or services which could be found elsewhere? Is it trying to be all things to all people? " she asked. "I do not have the answers," she said, "but answers can be found."

In her report, Sheila Quinn, executive director of the ICN, spoke of the move of ICN headquarters from London to Geneva in 1966, adoption of the new ICN Constitution, and changes in headquarters' staff. The move to Geneva has made possible closer cooperation with other international organizations, Miss Quinn explained. This has been demonstrated by informal inter-organization staff conferences with ICN, the World Health Organization, and the International Labor Organization, she said.

Despite the continued shortage of executive staff, ICN has provided advice and assistance to several nurses' associations seeking to qualify for membership, Miss Quinn pointed out. "Difficult though this quadrennium has been, it has not been without the satisfaction of having faced considerable challenge and somehow having achieved the near impossible," she concluded.

Miss Quinn also read the report on ICN publications – the *International Nursing Review* and *ICN Calling.* In the first year that the *Review* was published in Switzerland, subscriptions almost doubled. The ICN is supporting a heavy financial loss with *ICN Calling,* she said.

Miss Quinn also provided information on a nursing legislation project authorized by CNR in 1967. This project, part of a two-stage program recommended by the professional services committee, resulted in the 70-page document, *Principles of Legislation for Nursing Education and Practice.* Funds from the Florence Nightingale International Foundation are financing the project. The plan of the second stage of the program, originally to hold a regional seminar for nurses, was expanded to an international seminar on nursing legislation, with possible follow-up regional seminars during the coming quadrennium.

Dr. Helen Mussallem, executive director of the Canadian Nurses' Association, reported on the planning for the Montreal Congress. She said that a manual based on Canada's experiences will be given to ICN for future reference.

Several items came before the CNR for its consideration. One that sparked the longest discussion centered on a recommendation in the report of the member-





Members of the Council of National Representatives are received by Archbishop Gregoire at the interfaith service.

Montreal's 140-year-old Notre-Dame Cathedral opened its doors to more than 5,000 nurses at the interfaith service on Sunday.

ship committee, one of the two standing committees of ICN under the new constitution. This resolution concerned the "second level nurse" and her membership in both the national and international association.

"Second level nurse" is defined as one with the next to the highest preparation to that of "nurse" as defined in the ICN constitution. The second level nurse is prepared in a preservice course with a definite curriculum, on completion of which a certificate or other recognition of competence is given. A national association has the right to define its own membership at national level.

"If the second level nurse is accepted into national membership, she should also be afforded the privileges of ICN membership," said Virginia Arnold, committee chairman, in proposing the recommendation. This statement brought delegates from 32 countries to their feet. The majority were opposed to the resolution in any form. Concern was expressed that in some countries the number of auxiliary personnel exceeds the number of nurses and that recognition of the auxiliary nurse might be detrimental to the nurse. On the other hand, some delegates said, when second level nurses have no association with the national nurses' association, their only alternative is to join a union.

Australia proposed an amendment to the main resolution to admit auxiliaries to ICN membership, but without voting privileges. In the discussion on the amendment, the Netherlands pointed out that without voting privileges, auxiliaries would not benefit from ICN membership. Australia withdrew the proposed amendment after matters of parliamentary procedure became involved.

As the discussion progressed, Ruth Elster, second vice-president of ICN, explained that auxiliaries could not be admitted to the ICN without changing the constitution.

After much discussion, the U.S. delegate moved that the main motion to admit auxiliaries to ICN be postponed for four years for further study by the ICN on the issues concerned. Ghana seconded the motion, and it was approved by the CNR.

Held over for consideration at the next quadrennium was a resolution calling for reopening some form of associate or limited membership in ICN for associations that at present either do not qualify for full membership or are of a size that makes full membership impossible. Discussion concerned problems of membership encountered by small countries with a small number of nurses – only three or four in some countries. One way to get around this, it was suggested, would be for these countries to enter into ICN membership as part of a regional group. The resolution for reopening associate or limited membership involved a question settled at the last congress in Frankfurt, Germany.

The report of the seven-member professional services committee was read by chairman Margrethe Kruse of Denmark. The report proposed that the exchange of privileges program for nurses be replaced by a service called "Nursing Abroad" and defined as "a service offering nurses from ICN member associations arrangements for salaried employment and/or study abroad"; and that ICN produce a leaflet including general information and guidance. This recommendation was adopted by the CNR after brief discussion.

The second recommendation concerned the recruitment of nurses to foreign countries. The resolution as amended by South Africa and approved by the CNR read: "That ICN believes in the right of free movement of individuals but deplores the tendency of certain governments and employment agencies to use undesirable methods of recruiting large numbers of nurses from one country to another." Canada pointed out that its objection was not against nurses working in foreign countries, but against travel





Governor-General Roland Michener, who opened the Congress, chats with ICN president Alice Girard and CNA president Sister Mary Felicitas.

Eighty-five countries were represented at the Congress. Here, the procession of member nations is led by Canada.

Sheer concentration. Simultaneous translation was provided for all major sessions into French, German, and Spanish.



ICN vice-president confer. Left to right: K. Pratt, 3rd vice-president, Nigeria; Ruth Elster, 2nd vice-pres., Germany; and Alice Clamageran, 1st vice-pres., France.



agencies that entice nurses to work in countries where they may be exploited.

The third recommendation of this report proposed the adoption of a statement on nursing education, nursing practice and service, and social and economic welfare of nurses. It was carried with one amendment: "In those countries where a Trades Union has been accorded the exclusive rights of negotiation, the National Nurses' Association should seek to achieve a situation where it can actively influence the negotiations conducted on behalf of nurses." This amendment was substituted for a paragraph which maintained that the national nurses' association was the proper representative of nurses, although "in some countries this is undertaken by a trade union or labor organization." The statement is intended as a guide for national associations in developing their own policies in greater detail.

Two items brought forward by member associations were approved. Australia recommended that ICN member organizations that correspond on nursing matters with organizations other than the ICN member body in any country should send a copy of the correspondence to the national association concerned. Australia also called for the adoption of a universal record of professional education and service for nurses. This record, intended as a document that would be issued once and added to as necessary, would be the property of the individual nurse who could get photostat copies when registering in another country or state, and would be accepted by licensing bodies all over the world.

A motion put forward by the Royal Council of Nursing, England, was adopted. It requests the board of directors to set up a study group to review ICN objectives and functions. The study group would confirm or redefine ICN's role and assess the achievements of its present structure and organizational pattern in relation to the role as confirmed or redefined. The board will decide whether an ICN committee or an outside group makes the study. A report is to be submitted in time for the next CNR meeting.

The final items on the business agenda were selection of sites for future meetings. The next CNR closed meeting will be in Dublin, Ireland, June 26-30, 1971. The next ICN Congress will be held in Mexico City in the summer of 1973 – a bright note on which to close the heavy business sessions.

Plenary Sessions

Few, if any, platitudes were heard during the plenary sessions held Wednesday, Thursday, and Friday.* The speakers were refreshingly frank in presenting their concerns about issues affecting nurses, nursing, and health, and the audience's response showed that they appreciated this frankness.

The tone was set by Canada's Minister of National Health and Welfare, the Honourable John Munro, who spoke candidly about obstacles that must be overcome if an efficient, personalized health care delivery system is to be provided to all people. His remarks – many of which could be considered controversial – showed a keen understanding of the problems that appear to exist in all countries. (Mr. Munro's speech is printed on page 38).

Following the Minister's address, The Honourable Milton Gregg, president of the Canadian Council for International Cooperation and a former federal cabinet minister, gave a prediction of health care for the future. He suggested that illness in future will result from the expenditure of nervous energy, rather than from overwork of the body, as machines continue to take over and life's complexities in-

*Plenary sessions are planned as educational days for nurses attending the congress. Internationally known persons present papers.



A member of the ICN Council of National Representatives casts her ballot for ICN officers, board and committee members.

Delegates from Iran study the agenda for the business sessions, which were held Monday and Tuesday.



crease daily for each person.

Mr. Gregg predicted that cooperation among countries will grow. "In this co-operation," he said, "nurses will have a vital part and add the humanitarian touch to international and governmental projects as they are more widely developed."

Technological change in nursing

Dr John D. Wallace, executive director of Toronto General Hospital, minced no words in telling the assembly that both nursing and medicine place too much emphasis on *art,* rather than *science,* in their educational programs. Forecasting that technological developments in the next 20 years will be even more spectacular than in the past, Dr. Wallace said that he is not sure that the health professions are prepared to advance with them. "I fear," he said, "that medicine and nursing will, through default, suffer the fate of the dodo bird that could not, or would not, adapt to a changing environment."

Dr. Wallace questioned whether the staff nurse should be expected to rotate freely through all departments of the hospital and be proficient in all specialties. This, he said, is impossible in this age of electronics and specialization.

In summary, Dr. Wallace pointed out the need for postgraduate educational programs for nurses; recognition of the role of the clinical specialist in nursing; and economic and status incentives to attract capable nurses who are more interested in giving direct patient care than in administration or teaching.

Nelida Lamond, a senior lecturer in nursing at the University of Natal in Durban, South Africa, reiterated Dr. Wallace's belief that nursing is not keeping up-to-date with technological change. To remedy this situation, she suggested that the fear of the "black box" of technology must be removed from the collective mind of the nursing profession and that pressure must be brought to bear on the authorities in each country to insist on facilities for formal education at relevant levels.

Technological change in administration

Lucy D. Germain, associate administrator of the Pennsylvania Hospital, Pa., said that modern technology enhances both the efficiency and effectiveness of management at all levels. Moreover, she said, it disturbs and pricks complacency, and challenges the work-a-day world to be ever aware of human values and human performance. However, she pointed out, technology is not a cure-all, and while enthusiasm for it runs high, it should not be permitted to overbalance its relationship with man.

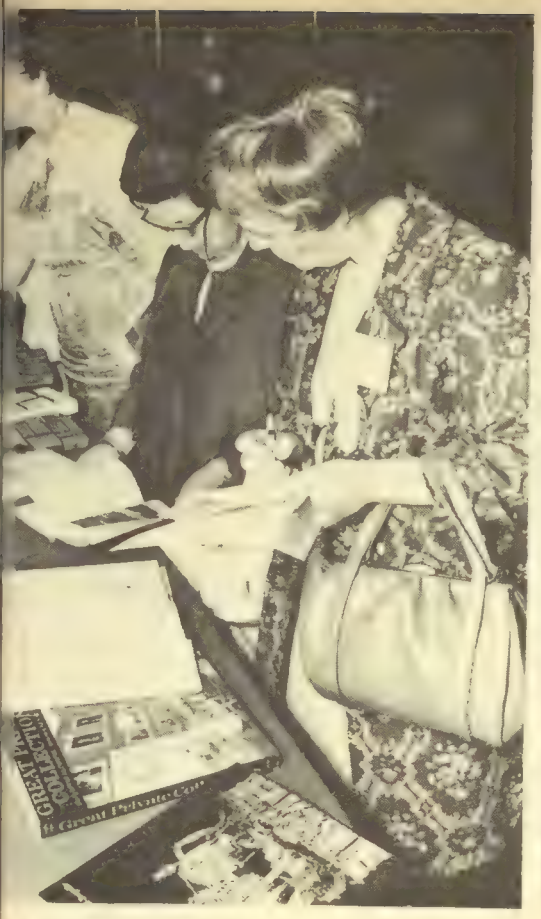
On the same subject, Sheila Iu, matron of a hospital in Hong Kong, said that the full potential of modern technology will be realized only when administrative practices are improved. And the key to better administration, she suggested, rests on good personnel policies.

Technological change and the law

Two speakers – a lawyer and a nurse – told the assembly how advances in technology have solved some problems, but have created new ones for medicine and nursing. Claude Tellier, a Montreal lawyer, explained that the nurse's present role in working closely with the physician and in carrying out extremely complex functions has created legal entanglements. "One of the problems facing hospitals today stems precisely from this sharing of functions and responsibilities by physicians and nurses," he said. "Although certain duties can easily be delegated to nurses, the law on the other hand remains the yardstick by which to assess the prerogatives of both physicians and nurses."

Speaking of legal problems that could result from organ transplantation, Mr. Tellier expressed the hope that new legislation will soon be enacted to define the procedure to be followed.

Julita Sotejo, dean of the College of



The many exhibits around Concordia Hall were a big attraction for the 10,000 nurses who attended the congress.

Speakers could be seen from all points in the hall as they stood on a revolving dias. Dr. John Wallace, shown here, spoke at a plenary session.



Nursing at the University of the Philippines and a lawyer, pointed out that the law is always "catching up – the law follows society and does not precede it."

Technological change has affected nursing in five major ways, said Dean Sotejo. It has relieved nurses of many tasks, enabled administration to make better use of nurses' time, instigated studies of nursing functions, stimulated the international flow of nurses to more advanced countries, and brought new problems that have new legal implications.

By way of example, Miss Sotejo listed eight actions normally taken in heart emergencies using technological equipment routinely operated by nurses assisting doctors. "Where a physician is not at once available, the nurse, seeing the need, may act," she suggested, but "because these are medical procedures, the nurse becomes liable for illegal practice of medicine unless otherwise authorized by law."

Miss Sotejo pointed out that technology has created areas in which the nurse needs legal protection on a personal basis. "What are the rights of a nurse who becomes incapacitated in the course of her work, say, from oxygen toxicity, from exposure to x-ray or radioisotopes? " she asked.

"As technology advances, more responsibilities, more problems, more risks and newer ways are forced on nurses. Our profession should discern emerging trends and forces and keep nursing abreast of the times."

Technological change, human relations

Dr. Leo Dorais, rector of the University of Quebec, Montreal, reminded the audience that technological changes are not unique to the twentieth century. It is only in more recent times, he said, that technological changes have meant, or have been associated with, a "de-skilling" of the individual.

According to Dr. Dorais, negative attitudes develop because society has not devised social techniques to cope with technological changes. In applying this concept to nursing, Dr. Dorais cited team nursing as an example. He said that team nursing has developed rapidly because of demands for health services in institutional settings, but that little adaptation and foresight has been applied.

In summary, Dr. Dorais stressed that good human relations can be maintained, even in the face of rapid technological change, when personnel are kept informed, and when changes are planned, thought about, talked about, and mastered by all those concerned.

Education for today and tomorrow

Philippe Garigue, dean of the faculty of social, economic, and political sciences, University of Montreal, compared the nursing profession with the family unit. The nurse traditionally has been seen as an assistant to the physician, now she is seen helping to put health policies into effect, he said. The patient is not only an individual with a disease, but a member of a family, all of whom are important to the patient's treatment and recovery.

"The nurse's role has changed," Dr. Garigue said, "she must understand the different levels of behavior patterns and the relationship between biological, social, cultural, and physical factors." "The effects of the nurse's actions extend to future generations and to the shaping of tomorrow's society," he continued. Nurses must also take another look at the reasons behind their actions "because the tensions and frustrations created by technological changes will have to be counterbalanced without making the tendency toward dependability worse than it is at present."

Nursing leaders from Finland, Canada, and the United States, spoke on the theme of basic programs in education for today and tomorrow. They agreed that methods used to prepare nurses at the diploma level should be updated to prov-

ide the quality and quantity of professional nurses required. Ingrid Hamelin, a nursing officer from Helsinki, Finland, reviewed patterns of basic nursing education – nonacademic hospital schools of nursing, independent schools of nursing, and academic university-based programs. She outlined a more recent development in the pattern of nursing education: the vocational school that prepares various categories of health workers in addition to nurses. In the vocational school, all students meet the same entrance requirements, and part of the theoretical program is the same for all, she said. In practical areas, each group concentrates on its special field.

"Since we are expected to provide the health services demanded by society in a changing time, are the present patterns of nursing education the right ones to prepare nurses for today and tomorrow?" Miss Hamelin asked.

Florence MacKenzie, associate director of nursing education, The Montreal General Hospital, continued on a similar note when she said, "It would seem that the hospital school of nursing has become an anachronism as nursing education in Canada begins a new era. Change is needed," she said, "but there is resistance. The resistance arises out of a lack of understanding that new programs can prepare a student to nurse in less than three years if her program is controlled by the school."

In the future, two types of nurses will be prepared – one in the university schools of nursing and the other in post-secondary institutions of learning, continued Miss MacKenzie. We need well-qualified teachers and expert nurses who can accept the challenge to meet the exciting and difficult task to prepare an adequate number of nurses for the nursing needs of tomorrow, she said.

Mildred Montag, professor of nursing education, Columbia University, New York, outlined the junior college program or associate degree program of nursing in the United States begun in 1952 as part of a five-year research project to develop and test a new type of nurse practitioner. "Because the colleges admit students regardless of age, sex, or marital status, the programs attract students of a much wider range than is usually found in the nursing programs," Dr. Montag said. There are now 413 approved programs of this type in the U.S., she added.

The most significant aspect of the associate degree program, according to Dr. Montag, is its ability to attract and graduate persons able to carry on the functions in the program. "It seems clear," she said, "that the associate degree nursing program will not only continue, but will become increasingly important in the preparation of nursing personnel."

In a panel discussion on university level programs, six nurse educators agreed that the university offers the best setting for nursing education. Chairman Rozella Schlotfeldt, dean of the school of nursing at Case Western Reserve University in Cleveland, Ohio, pointed out that nursing education should focus on people, not things. "Caring is indeed therapeutic; we must consider man and the social system. Nursing is nursing and not technical doctoring," she added.

Sheila Collins, principal tutor in a London, England, school of nursing, agreed that good education is possible no matter where the budget comes from. The university, however, has something to offer nursing, she said. The method of teaching, the opportunity for independent work and research, and the quality of teacher are unparalleled, she added.

Mohammed Abdul Ahad, principal, School of Nursing, Victoria Hospital, Bangalore, India, observed that even in the poorest countries, physicians, clergymen, and lawyers are educated in the university. Why not nurses? he asked. If nursing lags for another two decades it will be 50 years behind, he said.

Luzmila Arosemana de Ilueca, director of the school of nursing, University of Panama, said there is a tendency in Latin America for nursing schools to move into universities, some on equal status with other schools in the university. The university provides increased relationships with other disciplines, she said.

All agreed that university education for nurses was essential, and that it is nursing's duty to gain public support and to establish nursing as a self-determining profession.

Aims for tomorrow

Jane Martin, director of nursing in the French Red Cross Society in Paris, said that higher education should define the specific service nurses are expected to render to society and lead to the creation of a group conscience.

"What do we hope to achieve through improved selection into nursing programs?" asked Rebecca Bergman, head of the nursing department at Tel Aviv University, Israel. She suggested that selection through research in nursing education would help reduce the attrition rate and help graduate nurses who are prepared to meet the needs of our changing world.

"Research findings have shown that high school grades and intelligence tests are reliable predictions of academic success," Dr. Bergman explained. Only 10 percent of high school students are interested in nursing and only five percent actually enter.

Education is a life-long experience for all human beings, pointed out Dr. Gerald Nason, secretary-treasurer, Canadian Teachers' Federation, Ottawa, during a panel discussion on "Teaching Tomorrow's Nurses." "Progress at the individual's own rate must replace lock-step systems run on mass examinations," he advised. "The limitations now hampering education are dying slowly but irrevocably," Dr. Nason predicted. "Underdeveloped countries are unhampered by the very traditions of which they have been deprived – they may well be able to take giant steps into tomorrow."

Jacqueline Demaurex, head of Le Bon Secours School of Nursing in Geneva, Switzerland, suggested that the educational program for tomorrow's nurses should take into account what the student already knows and teach her how to learn, organize, and transfer learning, and to cultivate attitudes of true research.

"Clinical teaching," said Miss Demaurex "is an essential element in a nurse's education, and must complement the formal teaching of physical, biological, and social sciences." Clinical teaching is most effective where people are: in families, in schools, in industries, in hospitals, and in homes for the aged, Miss Demaurex believes.

Principal Winnifred Hector, St. Bartholomew's Hospital London, England, urged nurses to copy from national network shows in producing effective audio-visual aids for nursing education. She cautioned teachers that a lesson does not become good just because it comes via TV, however. "Nurse-teachers have to impart to their students factual information, technical and social skills, methods of thought, and personal attitudes," she said, "and the methods they use should be as varied as these aims."

Security for tomorrow

Health care economics, socialized medicine, and the professional association's responsibility for the economic security of the nurse were topics discussed Friday morning.

Speaking of the nurse and her professional security, Elizabeth Cantwell, director of the American Nurses' Association's economic security department, said emphatically that nursing must "deliver the goods or face annihilation." Miss Cantwell urged nurses to be as aggressive

It wasn't all work. Joyce Nevitt (in wheelchair), Director of the School of Nursing at Memorial University, Newfoundland, talks to a U.S. friend at a reunion of the Nursing Education Alumni Association, Teachers College, Columbia University.

At the same reunion are, left to right: Marie Loyer, faculty, University of Ottawa; Virginia Lindabury, editor of The Canadian Nurse – a guest at the reunion; and Dorothy Mumby, director of public health nursing in London, Ontario.









Harriett Sloan (left), the Canadian Nurses' Association's coordinator for the ICN Congress Committee, confers with Sheila Quinn, ICN executive director, during a break.

With 10,000 nurses hungry and ready to eat at the same time, you bought your box lunch and ate it where you could.

in their demands to speak on policies that determine the quality of nursing care as they are in pressing for full professional status and freedom from economic want.

Gerd Zetterstrom-Lagervall, a member of the ICN board of directors and president of the Swedish Nursing Association, spoke about the professional association and economic security for the nurse. She listed 16 points considered most important for a nurse's economic security, and said that the professional association can help nurses to achieve these goals through negotiations with the employer. The negotiable items she listed included provision for salary during pregnancy and childbirth, illness, injury on duty, leave of absence for study, and military service; compensation for overtime service and for inconvenient working hours; group insurance and pension plans; and vacation time.

To be of use to its members, a professional organization must keep itself informed of what is going on in society, Mrs. Lagervall said. Moreover, she added, the organization, which is nonpolitical, has to make contact with members of parliament who belong to different parties to give them information, to obtain information, and to try to influence their decisions.

Leadership in action

Leadership was examined – from every angle – by a well-known sociologist and four nurses Friday afternoon during the final plenary session.

Dr. Robert K. Merton, Giddings professor of sociology and associate director of the Bureau of Applied Social Research at Columbia University, New York, told the assembly that at least one thing is clear about the subject of leadership: it has not suffered from neglect. He added that there are still individuals who believe, as Aristotle believed, that from the hour of their birth, some are marked out for subjection, others for rule.

More recently, Dr. Merton said, social science has changed many of its concepts about the so-called leadership traits. Leadership does not result merely from the *individual* traits of leaders, he said. It must also involve attributes of the transactions between those who lead and those who follow. Dr. Merton noted a basic distinction between authority and leadership which is "fundamental to understanding that leadership can be found at every level of an organization. The leaders, the influentials, sometimes hold formal offices of authority; sometimes they do not."

What makes for the joint exercise of authority and leadership? According to Dr. Merton, four conditions must be met: the person receiving a communication must be able to understand it; he must be able to comply with the directive; he must believe it is in some degree consistent with his personal interests and values; and he must perceive the directive as consistent with the purposes and values of the organization.

Leadership is not simply a mystique, concluded Dr. Merton. "Slowly our understanding of leadership grows and sometime, perhaps, it will emerge from the sociological twilight into the full light of day."

Discussing leadership and the administrative process, an Australian nurse told the assembly that nurses on the whole are narrow in vision, apathetic, and at times petulant. Joyce Rodmell, president of the Royal Australian Nursing Federation, blamed much of this rigidity on the outdated, autocratic methods being used by administrators. "Of all the occupations, nursing has surely been the last to see the need for change in this field," she said.

The trend in school, in the home, and in the community is to encourage greater individual freedom and initiative, Miss Rodmell remarked, and young people today are less willing to be seen and not heard, or to accept the old saying, often





The red-jacketed members of the Royal Canadian Mounted Polic band entertained an appreciative audience in Concordia Hall.

This young lady was so absorbed in her reading at the "Library Too Exhibit" that she didn't even notice the photographer.

ICN president Alice Girard (left) and CNA executive director Helen K. Mussallem (right) congratulate newly-elected ICN president Margrethe Kruse of Denmark.



New associations admitted to ICN membership include: Argentina, Bermuda, Bolivia, Costa Rica, Ecuador, Lebanon, Morocco, Nepal, Portugal, Salvador, and Uganda.



heard in nursing, "You are here to do, not to think." The nurse administrator must change, she said, and accept and practice modern administration based on leadership, not autocracy. Otherwise her status will deteriorate further and, more important, fewer students will be recruited to nursing, she warned.

Speaking about education for leadership, Antje Grauhan, director of a university school of nursing in West Germany, said that most nursing education is compulsory and leaves little discretion to the student. She finds that the students' initial enthusiasm is often dampened and creativity squelched by the tightly regulated hospital.

A "systems approach" to hospital nursing was suggested by Jytte Kiaer, director of the division of nursing administration at Aarhus University in Denmark, in her discussion of leadership for technological advance in nursing.

Mrs. Kiaer views the hospital as composed of two major subsystems: medical service and nursing service. Only by a systematic analysis of nursing functions can a hospital make the best use of technological sciences, she said, and allow the nurse to devote more time and effort to human relations – the most indispensable ingredient of nursing.

Analysis of nursing services might be based on such things as physical environment, methods, patients, nurses, reporting methods, Mrs. Kiaer suggested. Systematic analysis might show that much information on patients could easily be transferred in a more concrete way. This would ease communication and make such information adaptable for automatic equipment, she suggested.

Charlotte Searle, head of the department of nursing at a university in South Africa, said that nursing leadership must ruthlessly remove basic causes of weakness within the profession, most of which result from inadequate educational preparation.

Dr. Searle said nursing leaders need courage to meet opposition of governments, hospital authorities, and others, and also to meet opposition from members of their own profession. "But no matter what forces have to be contended with, the quality of nursing leadership will be the real determinant in shaping the future of nursing," she said.

"Unity" is watchword

The formal meetings of the congress came to a close on Friday evening. Each of the several thousand nurses attending the closing ceremony took home with her a word that will become the password to the next congress to be held in Mexico City in 1973, four years from now.

Alice Girard, retiring president, said that *unity* is a guideword that has been part of her personal philosophy for many years. "It seems essential to our survival as an association to preserve unity," Dr. Girard said.

Unity represents a loyal and continuous search for the truth in our goals and a union of faith in our methods, she continued. Failure to meet our objectives does not mean that we have lost faith in one another or our methods, but only that we have encountered the inevitable obstacles from which may come better understanding. "Intelligent compromise is often the evidence of courageous wisdom," she pointed out. "We seek an association of good will, mutual respect, reciprocal confidence, and unselfish cooperative endeavor," she said.

Dr. Girard left her audience with a thought that vividly illustrates how futile efforts can be without unity and a sense of brotherhood: "What is the sound of only one hand clapping? " she asked. □

A challenge that confronts us

Mr. Munro presented this speech at the opening plenary session of the 14th Quadrennial Congress of the International Council of Nurses in Montreal on June 25. Because of the important issues and possible solutions raised by Mr. Munro in this paper, we present it in its entirety.

The Honorable John Munro,
Minister of National Health and Welfare

In opening my remarks, I would like to say that I am truly impressed at the size and the nature of this gathering. I suppose that if any time is appropriate to get sick, today is the right day for it.

But this is no time to discuss sickness. Rather it is a time to discuss health – the health of our people, and the health of the nursing profession. I see that your theme – *Focus on the Future* – reflects this outlook.

I should, at this time, convey on behalf of the Canadian government our best wishes for your meeting's success. We are honoured that such an important multi-national organization, in such a significant field of human endeavour, has chosen to come to our country for its conference. I would also add that we have an interest far surpassing that of mere courtesy in the subjects you will be tackling, and will be looking forward to the benefit of your internationally concerted thoughts on reforms of the health delivery system.

We are interested in these views, notwithstanding the apparent economic strength and vigour of our young country. We are considered, I know, as one of the richest of the western nations, and some of our affluence, especially in medical personnel, must seem like extreme opulence to places that have very large disparities in doctor-to-population and nurse-to-population ratios.

Yet we are far from perfect. We have a small population, spread over the second largest area of any country in the world. Obviously, this creates enormous problems in getting care to the people. Thus, we must concern ourselves as much with the distribution of our medical resources as with the raw amounts of them.

And, I must confess, we have not yet reached Utopia on this important question of distribution. We have very serious gaps in the total framework of health care. If, in Vancouver, it's a feast comparable to the banquet of Balthazar, then in some of our urban slums, Maritime towns and villages, and Indian settlements, it's truly a famine.

Not that either the feast or the famine are inexpensive. The Canadian taxpayer is spending a sizable chunk of public money for hospital insurance, and soon the full impact of the medicare program will be dropped on top of this. This gives rise to a fundamental point: for all the money, shouldn't we be able to expect that all our citizens are more or less equal in terms of access to necessary health care? – an access that we have come to accept as a fundamental human right, after all.

So, the challenge is two-fold. The first is to reform the delivery system to extend treatment and services to all corners of our vast land and all segments of our highly diverse population. The second is

to avoid bankrupting the common treasury in the process.

This may sound contradictory. It isn't. I make that as a flat statement because I know what can be done if we really care about seeing that it is done. And, in the meeting of this double challenge, the nursing profession has a definite and an expanded role to play.

I know that you want to play such a greater role. For one thing, I know that you care deeply about returning the practice of health work to the most meaningful basic unit – the human being, the individual, the present or potential patient. There has been an erosion of this recently. Many of your colleagues feel frustrated within a system that seems to be turning you more and more into bureaucrats – paper-pushers, red tape merchants. It may seem, at times, as if you have escaped the bedpan era only to graduate into a mindless round of tramping painfully through a swamp of administrative detail. You too are becoming part of the depersonalization process of modern life, that process which tends to reduce men to a role of computer card digits, whether on the job or in the hospital. It is this depersonalization that leads to the alienation which, as we have seen, can cause the most violent social eruptions in the streets of our so-called enlightened affluent western democracies.

For this reason, I support your viewpoint on care. I think it's high time to get the nurse back into nursing. And, with your sufferance, I'd like to throw out a few suggestions on how that can be done.

An important opening step would be to cut the chain that tends to bind the



The honorable John Munro, Minister of Health and Welfare, chats with Alice Girard (left), former president of the International Council of Nurses, and Verna Huffman (center), principal nursing officer, Department of National Health and Welfare.

modern nurse to the hospital. Don't get the impression that I am against nursing in hospitals. If, when I leave the meeting this morning, I were to be struck by a car, you can be sure I'd want to have some nursing services in a hospital context, and rather quickly too.

What I am suggesting though is that the nursing profession as a whole shouldn't be dependent on hospital work in the same way as an infant depends upon the umbilical cord. The figures do show a rather high correlation between nursing and hospitals. There are over 130,000 registered nurses in Canada, and I note that only about five percent of them are in public health work. Yet, to a large extent, I believe that the latter direction is where the future lies. I, and many health officials, at any rate, feel it lies to a greater extent outside the active care hospital than at present.

Unfortunately, public health work has tended to pick up a bad name. Perhaps that is a fault of restriction in terms and areas of practice. So I'll make my definitions clear. Public health should mean health care provided to the public at large.

Let there be no doubt that such care is needed. There are the gaps I have already cited. In addition, a little rule of thumb that I have mentioned to other groups before is perhaps instructive. We estimate that of 1,000 people who need medical attention, 275 actually get to see a doctor, and only 10 ever get assigned to a hospital. Now not all of the other 990 not admitted need hospital treatment. But the 725 who don't see a physician should see somebody who knows something about sickness and its correction.

Many of these people, of course, are unaware that they may need attention — that is, until they are carted off to that unexplored land that Hamlet talked about. I think I should add that not many of the 725 tend to be in any of the high income tax brackets.

Somehow or other, this ratio has got to be set into a better balance. One of the best ways that it can be is through greater public health work, not only by nurses, but by all types of physicians, as well as other health personnel.

But if public health has too much of the connotation of immunization clinics and even more staggering amounts of paper work, we could call the process: community care. This means leaving the active bed ward to go out into the field and discover cases of need, perhaps in time to treat them before they wind up in these very active-care beds.

Right now, I am talking about expanded services. Very well, some may say, but how do you reconcile that with the need for cutting costs?

Let me set it up this way. The earlier sickness is detected, the less expensive the treatment tends to be. Moreover, public health is more than broader discovery and diagnosis; it's preventive medicine as well. One of its essential functions is education. To point out one example, education on proper nutrition can avoid a lot of subsequent disease — of the bones, of the heart, of the liver, and so on. In another field, early education on fluoridation can cut down a lot of future expensive cavities and extractions.

Alright then, the critics will say, you can cut expenses in the long run — but what about the here and now? The more you go out into the community at large, the more you will find people who do need to see a doctor, and more people who will be hospitalized. How are our doctors and hospitals ever going to cope with this increased demand?

The answer to that is, very bluntly, that we can probably accomplish it by reducing the dead wood in our present facilities. That may sound harsh, but I feel it's true. Hospitals often seem to be erected more as municipal monuments than as realistic treatment centres. Patients who could be treated just as well at home, or in institutions of special care, such as convalescent and chronic care homes, are frequently left in enormously expensive active-care beds. This sometimes seems to happen just to satisfy convenience, or to increase the "take" of medical personnel who are far from starving at the present time.

Let me also point out that giant hospitals are often built, or often expanded, simply to satisfy civic pride, or add to professional points of status. As I mentioned to the Canadian Hospital Association in May, what is the sense of a process that results in three hospitals, located in the same city, under one university jurisdiction, within a mile of each other, performing three separate heart transplants in the same month.

Greater planning, I am convinced, would show that in many areas facilities are far outstripping real demand, and what's worse, are blocking expenditures in places of true, and often desperate, need.

There is one point of extreme importance to Canadian nurses and other non-physician hospital personnel. Hospital costs are escalating so rapidly at present that provincial treasuries are reaching the bursting point. Unless we can stop this escalation, and unless we can effect some real economies in this field, and in the field of the costs of physicians' services, then there is going to be very little left short of bankruptcy — or even higher taxes — to improve the salary conditions of those at the lower ranks on the scale.

So hospital dependence and its high expense can and must be reduced. They can be reduced by moving out into the general community. But this move cannot be accomplished without the active participation of the nurses.

There are a host of ways that this can be done. More nurses can be trained in the specialized field of home care and home nursing. That doesn't just mean holding hands with the bedridden child who has mumps. With more aggressive home treatment programs, it can mean preliminary investigation visits, follow-up visits on treatment prescription, specialized medicinal supervision, and other responsible tasks. They can be at least as meaningful, and should be even more meaningful, than the treatment of similar patients who are now in hospitals — and they are less costly. As an example, I would cite an experiment in the Ottawa area which showed that patients now being treated in hospitals at $42 a day and more could just as easily and just as adequately be treated at home — with probably a far better personal appreciation of the reception of care — at a cost of $12 a day or less.

Another alternative is joining in the formation and operation of community health clinics. These places, as part of the anti-poverty work of the Office of Economic Opportunity in the States, have been shown to be capable of transformation into neighbourhood health "drop-in" centres. They can be more than just pill dispensaries; they can be integral parts of social development programs and overall community regeneration. They should involve doctors, social workers, dieticians, and psychiatrists as well as nurses. In other words, they should be the mobile out-patient clinic — not just putting out fires through emergency treatment, but stopping fires before they start. They bring the remote white-coated, cold, and impersonal world of organized medicine down to an understandable, available, and friendly people-to-people basis.

There are places where these centres are urgently required. I am contemplating the often appalling lack of facilities in our urban slums and ghettos. I am thinking of enclaves of the alienated drop-outs of society — such as the youthful drug communities like Yorkville. I am thinking of every location where we have failed as

a society to prove that we have something to offer – something of value that can be shared.

Health care is only part of the job that such centres can dispense. They can dispense hope and counsel that can revitalize the lives of our depressed, our disadvantaged, and our down-trodden. Even disregarding the impact on current health costs, I think that the benefit of such operations in social rehabilitation alone can save our population untold amounts – and what's more, can help conserve our most precious resource – people – by bringing them back to productive lives. One thing we do know: someone who's sick and feels cut-off has little incentive to struggle back into the mainstream. Community health care can correct this waste of human lives and human talent.

Team practice in the family care field is another opportunity to bring the nurse back into touch with the patient. As we realize more and more that increasing physician concentration on more abstruse specialities reduces to a greater and greater extent the scope of medical practice, a counter trend is taking hold. There are some doctors – a growing number, I believe – who really care about the total man, just as I am told that there are some doctors who know how to work with a nurse, without assuming that she is their personal servant. Such doctors, on an interdisciplinary basis, are moving back into the field of direct family care through the formation of large practice units. In such units the nurse should play a vital part.

In all those roles I have outlined, the nurse becomes a far more important member of the health team. She accepts greater responsibility and more independence. But I do not think that those trained to follow in the footsteps of Florence Nightingale shrink from proving that they are 100 percent capable of using their God-given intelligence for more significant tasks than filling in forms.

As a matter of fact, I know personally that this is not the case. I have seen young girls carry a health load that would stagger many doctors. Where I saw this was in our own Canadian northland.

The North is a land of promise, or as the expression there has it, the Big Tomorrow Country. It is potentially rich, it is exciting, it is beautiful. It is a land as big as the men and women who are carving out its future right now. But it is also, at present, a monstrous health problem. Particularly among our isolated native people, disease rates are higher, accident rates are higher, both children's and adults' mortality rates are higher – much higher – than they are in our southern climes.

Facing up to the job square-on are our Indian and Northern Health Service nurses. In the Yukon and the Northwest Territories, roughly 150 of them tackle the burden of 50,000 people spread over one and one-third million square miles. Added to those who work in the remote Indian settlements in the northern areas of our provinces, you can see that these women are bucking up to a Herculean task – and they are doing a fantastic job of meeting it. The nurse in an outpost health station isn't just a 9-to-5 bureaucrat. She's a 24-hour nurse, public health worker, dentist, midwife, and even doctor. Without these nurses, I shudder to think what might happen to the people north of the 60th parallel.

Unfortunately, I must confess that not all are Canadian. In fact, far fewer than a majority of them are. So I am afraid I must apologize to many of the delegates here for the fact that we're draining off their scarce resources to look after our North. However, I am hopeful that the Canadian delegates, representing leaders of the profession from coast to coast, will carry the message back to their homes of the task and the opportunity of northern services. I am not issuing a call of the Wild; I am issuing an appeal of the heart that our girls recognize that there are more worthwhile aspects to life than settling down to a dull middle class existence, with a suburban mortgage, 1.2 automobiles, and 2.2 children. All these can come in time – but I think our young students would want to be able to say, before this happens, that they have done something truly constructive and essential in their career.

But I wish to draw more from this illustration than a recruiting pitch. I wish to point out that it is silly to draw an artificial geographic barrier on a nurse's capability. Is there some magical power a nurse possesses that she suddenly loses when she crosses the border of our Northern Territories? I hardly think so.

I think that a nurse in the south of our country can be fully trusted, with proper training, to handle at least half the tasks her northern sister does routinely. In this process, I think she can take a good deal of the volume load off our doctors, freeing them for jobs that their extended educations qualify them to do.

Let's look at infant care as an example. Why should normal deliveries and well-baby care be the exclusive preserve of someone who's spent up to 12 years mastering the most complex techniques of modern medicine? In Europe and the rest of the world, this is not the case. Thus it is said that the North American obstetrician is the most expensive midwife on earth. Why not cut his expensive caseload by instructing nursing students in such fields? That way, the obstetrician could use his or her talents to their full potential.

There are many other categories of medical care where the same thing applies. Therefore, we should not wonder why we have under-serviced regions, and waiting lists for needed treatment. But if routine could be cut, our doctors could become more mobile, and move where their services were called for.

Take hospitals. How much of preliminary examination work, application of splints and dressings, and simple respiratory treatment really needs a doctor's attention? If the nurse carried more of this burden, not only would overall hospital costs and physician's costs be lessened, but the patient would benefit from a closer relationship with those most active in his daily care. We could evolve a nursing care plan that is a true reflection of the patient's need.

At this point I must confess a shortfall of expertise. I do not know exactly how the health professions could be reorganized properly to utilize better existing talent without a drop in the quality of care. But I do feel that reform of health education is possible, is feasible, is practical, and is necessary.

There is talk of a new category of super-nurse; there is talk of a Feldsher system. Which avenue is best is a fact I do not pretend to know. But reform and reorganization must come, not only in education, but in patterns of practice. We owe it to the Canadian population.

Therefore, I call on you to devote serious thought to this question. I call on you to consider our challenge as your challenge. I call on you to come up with ways in which the nurse has the greater independence and responsibility she needs to live up to her potential. I call on you to upgrade the role of nursing in the care of the sick and the improvement of society. In other words, I call on you to join in the total restructuring of the health care delivery system. □

Laval University accepts a challenge

Laval University recently launched an exciting new educational project. The ultimate goal is to prepare a harmonious body of professional health workers, rather than a variety of specialists. The program of studies offers both pragmatic learning and empirical knowledge, general scientific information, and specific professional preparation at one and the same time.

Jacques Brunet, M.D., F.R.C.P. (C) and Claire Gagnon, M.Sc.Inf.

For many years, students in the various health disciplines have received their educational preparation either in professional schools or in universities with distinctly separate faculties. Only recently has thought been given to the need for a more comprehensive program that would provide students in the health professions with a common body of basic knowledge.

This new approach has already been demonstrated by educational institutions in other countries as well as in several provinces in Canada. Within the university, this structure has come to be known as the "health sciences complex." The university carries a heavy load of responsibility with respect to the preparation of health workers – total responsibility for some groups, partial for others. The limits of its role and responsibility must be set by the institution itself.

Traditionally, the health team includes doctors, dentists, pharmacists, and nurses. To these must be added teachers and research workers, such as anatomists, physiologists, biochemists, microbiologists and others. New groups, such as clinical psychologists, medical social workers, dietitians, speech and hearing specialists, and physiotherapists have joined the ranks more recently. There is a growing demand for the services of these new groups, but as yet their numbers are rather limited. Generally speaking, these persons hold university diplomas, baccalaureate, masters' or doctoral degrees. Finally, there are the technicians in such areas as radiology, medical laboratory work, medical electronics, electroencephalography, physiotherapy, social work, dentistry, and many other departments.

In 1967, Laval University recognized the importance of the comprehensive approach and created the environment necessary to facilitate development of a health sciences complex. A vice-rector responsible for the health sciences and a permanent committee were appointed. In September 1968, a new study program was set up under the guidance of the faculty of medicine. The first stage is a three-year block of studies leading to a baccalaureate in health sciences. The courses offered are of a general nature, while at the same time they open the door to the pursuit of more specific goals.

Dr. Brunet, Associate Professor, Faculty of Medicine, Laval University, is a graduate of Collège St-Charles Garnier and Laval University. He interned at Hôpital St-Sacrement, Quebec City, then went to the University of Pennsylvania for postgraduate medical experience. He carried out research in endocrinology at Jefferson Hospital, Philadelphia, and later took advanced study in internal medicine and endocrinology at Guy's Hospital, London, England. Claire Gagnon, a graduate of the University of Montreal and Teachers College, Columbia University, is Nursing Consultant to the minister of health for Quebec, and Director of the School of Nursing, Laval University.

Objectives

The first objective is to help the student attain scientific and intellectual growth. Like any other undergraduate program, the baccalaureate program in health sciences is designed to give the student the intellectual background necessary to foster independent thought. He learns to study by himself, develop insight, and find the solutions to a given problem through his own efforts. Personal study habits are developed through the use of self-directed projects, such as seminars and occasional written assignments. Practical experience in scientific or analytical method is provided through individual, in depth study of certain material. Each student enrolled in this program chooses a particular group of related subjects for intensive study.

The second objective, "orientation and personal development," is the result or consequence of the first. Sufficient flexibility has been built into the course of studies to permit its adjustment to individual needs and thus encourage personal development. Consideration has been given to the differences that exist in regard to previous education, individual interests, and ambitions.

The baccalaureate program in health sciences attempts to improve communication among health workers and to help them develop a sense of unity through common interests. As a result of experiences and courses shared during their university years, graduates should have a

greater appreciation of the unity of purpose that binds them together. This particular aspect will be of prime importance for those who eventually become involved in patient care.

The fourth objective is to assure a uniform quality of teaching, and is achieved through the regrouping and coordination of teaching programs. Good use is made of university teaching resources, and a uniform quality of instruction is assured.

To meet more specific objectives, material basic to an understanding of the functioning of the human being is taught. This includes physiology, biochemistry, microbiology, pharmacology, anatomy and histology, psychology, sociology, anthropology, and economics.

To achieve the various general and specific objectives of the new baccalaureate program, the committee on the health sciences substantially reduced the amount of material to be committed to memory so that the student could devote more time to study and reflective thinking. Each course is divided into periods of theoretical teaching alternated with practical experience and supervised personal projects. In addition, study courses are arranged so that clinical, social, and psychological aspects are presented in conjunction with more theoretical detail in the biological and behavioral sciences. This plan goes into effect in the first year of study and is intended to make the student more aware of the close relationship that exists among the different fields of interest.

Flexibility in course choices

The program includes a certain number of courses designed to equip each student with a body of knowledge basic to all branches of the health sciences. Other subjects or blocks of selected subjects provide for indepth investigation of specific areas or complement the general program.

General courses

All students enrolled in the health sciences program are required to take subjects such as physiology, anatomy, and so on. These subjects have been selected to provide basic knowledge related to general principles in the basic sciences. Interdepartmental cooperation has made coordination of several of these courses possible.

Selected courses

Selected courses fall into two categories, complementary or intensive. Complementary courses are courses chosen by the student from areas other than those that constitute his main field of interest. They contribute to his general and professional education.

Intensive courses are related to fields of special concentration and are grouped accordingly. This type of course has a bearing on the fundamental ideas of the health sciences and on the scientific content by reason of its intellectual interest for the student, rather than its value on a strictly professional or utilitarian basis. In other words, such courses allow for exhaustive study in an area that has some special appeal for a student. Appropriate combinations of courses, either in the molecular, biological, psychological, or social sciences, form the chief areas of concentration during the last two years of the baccalaureate program.

School of nursing sciences

Since its opening in September 1967, the School of Nursing Sciences, which is affiliated with the faculty of medicine at Laval, has depended on professors in the biological sciences for assistance with its teaching program. The first students enrolled in the school studied physiology with the medical students. Courses in biochemistry, anatomy, and bacteriology also formed part of the study program, but were taught by lecturers from the faculty of medicine.

During the 1967-8 university year, the rector appointed the permanent committee of the health sciences. Its members were drawn from the faculty of medicine and affiliated schools. The committee is chiefly concerned with the organization of the health sciences complex and with the preparation of study programs in accordance with stated objectives. The School of Nursing Sciences is represented by two professors, thus assuring communication between the school and the faculty of medicine.

In September 1968, 33 new students enrolled in the school and became an integral part of the new body of health science students. They study the same courses, share the same laboratory work, and must write the same examinations as their colleagues in medicine, pharmacy, and physiotherapy. An introductory course in nursing care provides the students of nursing science with an introduction to their future professional career.

During the second and third years, the course of study focuses more directly on the student's preparation for nursing. Nevertheless, she continues to follow certain intensive courses in company with the other health sciences students.

University hospital

For a university to become a center for both education and research in the health sciences, it must be closely affiliated with a hospital. Students of all disciplines use the hospital's facilities for clinical experience, and team work-habits soon develop.

The staff members of a university hospital center have a responsibility to participate in advanced programs for all health professionals in accordance with the specified objectives of the university teaching program; establish standards of care; promote exchange of ideas and foster good relationships among the various members of the health team; and carry out medical and multidisciplinary research that promotes advances in knowledge in the health sciences.

The first step in this project was taken in September 1968 when Hôpital Ste-Foy became the Medical-Hospital Centre for Laval University, under the jurisdiction of the minister of health for Quebec. This hospital was previously owned by the federal government and used for the care of war veterans. When the official ceremony took place in December 1968, the Quebec government handed over the ownership of the hospital to the board of the University's Medical Hospital Centre.

Administrators, doctors, nurses, and other health professionals are presently striving to make this hospital a center where the quality of clinical teaching and patient care will be assured, and research programs will be developed.

Conclusion

The team spirit should develop more readily in the health science workers who, throughout their university experience, have had an opportunity to become familiar with the principles and procedures underlying the work of various health disciplines. Each profession has its role to play, a role that is always complementary to that of others; each discipline contributes to the fulfillment of the total therapeutic plan for the patient.

The initiative shown by Laval in the field of the health sciences clearly proves that institutions of higher learning can take a tangible interest in the welfare of the general public. The ultimate result of improved teaching programs and support for research will undoubtedly result in better patient care. □

Mind your own business

Nurses need to be aware of laws governing themselves and the other health professions. In fact, nurses and their professional associations need to make it their business to be in on the law-making processes. This article reviews new additions to the Quebec Hospitals Act with respect to nursing.

Claire Dutrisac

As the result of an Act passed in 1963, the Quebec government was empowered to exert a certain degree of control over hospitals. The Act was very general in nature and required additional detail in some areas. For example, Articles 20 and 21 delegated the responsability for drafting medical regulations to the Quebec Hospital Association and the College of Physicians and Surgeons. The government was to draw up administrative guidelines. When the QHA and the College found themselves unable to agree, an order-in-council relieved them of their privilege to draft the regulations and the privilege reverted to the government.

Now, after years of procrastination, the Quebec government has finally released the medical and administrative regulations anticipated by Articles 20 and 21 of the Hospitals Act. On the whole, they are excellent, and should bring some order into the confusion that has resulted from lack of direction.

The main emphasis in the new Articles is on medical practice, which is as it should be. Administrative practices have been considered from a qualitative rather than a quantitative viewpoint. However, much emphasis has been put on nursing care as an integral part of adequate medical care. This area appears to have been poorly investigated and is therefore worthy of our concern.

Fundamentally, all services are essential to good hospital function. The patient



needs a proper diet, clean clothing, and so forth. However, all services cannot be compared on an equal basis; their importance is relative. Nurses are treated as ordinary employees in those sections of the regulations devoted specifically to them. The effect of these regulations should be considered, especially from the point of view of the director of nursing, the staff nurse, and nursing personnel in general.

A few preliminary remarks are in order. Article 3 stipulates that every hospital will be classified; the implication is that this has not been done. Such classification should precede any statement of general regulations as it may be impossible to impose such regulations on all hospitals indiscriminately. A teaching hospital is administered differently from any other; the specialized hospital varies as to form of organization; a 50-bed institution cannot be compared with the 400-bed hospital. Surely it would have been easier to draw up regulations according to hospital categories.

Moreover, the provision of nursing care is a special factor to be considered in classification. The nursing care standards issued by the minister of health for Quebec have already created numerous problems in application, especially in smaller institutions.

The definition for paramedical personnel could readily encompass nurses: "All persons other than doctors and dentists who, by reason of their qualifications and at the request of the physician, share in diagnosis and carrying out of treatment." In another section, nursing personnel are specifically described as all persons qualified to give nursing care to the ill. We can only assume that somewhere a distinction has been made.

What constitutes nursing care has not

Claire Dutrisac is a journalist with *La Presse*, Montreal, and specializes in matters related to health and welfare. Her report of the heart transplant performed on Mr. Gaetan Paris at the Institut de cardiologie de Montreal won for her one of the most coveted journalistic prizes in Canada under the National Newspaper Awards.

been specified. Does it include giving a bed pan, collecting urine, changing a bed, administering a bed bath? The definition is faulty. A further reference to the present nursing care standards laid down by the Minister of Health would also be appropriate.

Hospital boards

Why are nurses not asked more often to be a part of the boards of management, which, under the Act, run hospitals? Or has this been done and nurses have refused to cooperate? Certainly when a public hospital is operated by a religious order, nursing representatives of the order often sit on the governing body, but I do not know of any lay nurses to whom this applies. It seems to me that they would have as much right to do so as doctors, lawyers, businessmen, notaries, pharmacists, accountants, dentists, and so on.

Apart from private hospitals, are there any boards that include nurses in their ranks? If so, it is a well-guarded secret. Under the terms of the Act, hospital employees can be represented on the board of management so long as their number does not exceed one-third of the total membership.

The Act also states that a member who is a physician shall be appointed by the medical board of the hospital. In addition, there must be a doctor on the executive committee. Is it completely utopian to hope for similar representation for nursing? I think nurses would have to present a united front, similar to that of the doctors, to make their participation in the control of the quality of nursing care absolutely necessary.

Staff turnover may make it difficult for nurses to become as unified a group as the doctors. On the other hand, such unification has a stabilizing effect and might help prevent such rapid turnover of nursing staff.

Another factor must be considered – the possibility of union objections to such internal organization. Modern nursing is assuming ever-increasing importance in diagnosis and treatment. Is it inconceivable to suppose that if nurses were organized as democratically as doctors, they could manage their own affairs?

Under the Act, unless the board of management decides otherwise, the hospital administrator and the medical director attend meetings, but have no voting privileges. Since nursing is so closely linked to medical procedure, why is the same courtesy not extended to the director of nursing?

The following note was placed on my desk on day by my city editor:

"A tearful mother told me that her little girl had had a kidney transplant and died. She said that the doctor had explained that there were not enough nurses and they were not trained to cope with such highly specialized operations."

If the mother's statements were accurate, these are serious accusations by a doctor against nurses. If there was a mistake, who was at fault? To whom can the nurse turn under such circumstances? Should the medical committee be responsible for investigating such cases?

A Toronto urologist recently declared publicly that lack of communication between nursing personnel and himself was the basic cause of death of one of his patients.

The respective responsibilities of nurses and doctors cannot be settled here. I am simply attempting to prove that the nurse carries too heavy a load to be treated on the same level as other employees.

The director of nursing

The director of nursing, along with the hospital administrator and the medical director, belongs to the administrative group. The administrator holds the ultimate authority for what goes on in the hospital by delegation from the board of management. Even the medical director submits to his control.

Usually there are five departments – including the medical department – under the administrator. The director of nursing, as chief nurse, wields considerable power. In fact, her power is so great that one wonders what recourse the nurse who displeases her has, apart from union protection. Since not every hospital in the province has a nurses' staff association, there are still some personnel at the mercy of arbitrary authority.

A doctor accused of a breach of professional ethics can defend himself before his peers. The nurse is not given such as opportunity. Her only alternative is to leave with a slightly tarnished reputation.*

Each hospital is free to establish regulations amplifying those passed by government. Thus, each hospital is free to develop some system of appeal against arbitrary judgment. One of the functions of the director of nursing is to set up the committees necessary to ensure good nursing service.

The suggested pattern is as vague as one could hope for. It is so vague that an enterprising director could readily develop a truly democratic committee on nursing. This body, in addition to investigating ways and means of improving nursing care, could be given the responsibility of studying accusations made against nurses by doctors, patients, or the public.

Article 75 gives the hospital medical board – the doctors – the freedom to include in its membership representatives from other health professions. This means that the director of nursing could be invited to attend meetings. But are nurses really looked upon as "health professionals?" I doubt it, although it would seem desirable that they should be.

At the present time, most medical boards would certainly not permit the director of nursing to be present, although Article 81 provides another opening. Anyone can sit in on meetings of the medical board or its executive by invitation. Have the doctors ventured to make such a gesture toward nurses as yet?

*In some provinces, an individual nurse can ask her provincial nursing association to investigate conditions on her behalf.

Article 76-g puts control of paramedical and nursing activities in the hands of the medical board. This alone should justify the presence of the director of nursing at meetings of this group. The hospital administrator, who is not always a doctor, sits in on meetings of the executive committee of the medical board; the director of nursing deserves these rights also.

Staff nurses

This group is without protection of any kind in the hospital hierarchy. Even the majority opinion of its members need not prevail against the wishes of the director of nursing nor of the administrator. What alternatives does she have but to submit or to resign?

The Act recommends a joint committee on nursing with equal representation from both nursing service and medicine, in addition to the administrator and the director of nursing. One of its functions is to investigate any complaints related to nursing. Could it not also act as a sort of court of appeal for staff nurses? Its make-up, however, leaves something to be desired. Three doctor members in addition to the administrator would seem to balance three nurses plus the director of nursing. We forget that this committee is under the control of the hospital administrator who frequently sides with the doctors when, to put it bluntly, the director of nursing does not balance the scales, but serves as a representative of administration.

It is a vicious circle. Committees formed for the purpose of overseeing nursing care are controlled by doctors, and nurses can do little except not assent. If, at their peril, they oppose the doctors, it is without hope of a hearing.

Although I believe that doctors have a place in this area, nurses should play a much greater role in the control of nursing.

Nurses have little protection in the practice of their profession. However, through force of circumstances, they are being called on with increasing frequency to carry out more and more complex medical procedures. Article 245, as an example, startled me somewhat. It states that in an emergency a verbal order can be given by telephone to an authorized person. The latter must record it on the chart along with the doctor's name, date, and time of the call, and then sign it. The attending doctor must countersign this order within 24 hours. The "authorized person" is often the nurse!

There is always the possibility of error under such circumstances. In most cases, the telephone treatment is successful. In other instances, unless the patient is examined by a doctor, he may die. The "authorized person" finds herself in an awkward situation if, in the face of a serious or fatal outcome, the doctor refuses to countersign his order or claims to have prescribed something different.

The only possible solution is to require the presence of at least one doctor in the hospital at all times.

Although taking a new and daring approach in several areas, the new regulations are weak with respect to emergency services. Article 228 says only that each hospital must have a doctor available at all times. There is no indication of where he is to be located, nor of what "available" means. Various nurses have complained about this, particularly those from non-teaching hospitals without intern services.

On behalf of the patient

Whether nurses like it or not, all of the foregoing considerations have a bearing on hospital classification. The duties and obligations of an institution are necessarily limited by its bed capacity, facilities and equipment, personnel, the area served, and the number of doctors on its staff. The nurse is also affected. Her responsibilities are likely to be proportionately greater in the hospital with more limited facilities than in the university teaching hospital where she is surrounded by medical personnel. On the other hand, since the latter provides more complex types of care, the nurse must be more highly specialized.

The newly-amended Act, as far as nursing is concerned, sums up a code of procedure concerning the organization of nursing service. In the overall picture, there is little concern with nurses. They are considered as nothing more nor less than hospital employees, although touching discourses on their calling are frequently directed to them. The role and functions of the director of nursing are clearly specified, which is one good point.

In Quebec, nursing personnel in general – nurses, nursing assistants, and nursing aides – have no other alternative than unionism. Even here there are limitations. Should the union stick to its traditional role of ensuring bread and butter for its members, or must it be concerned about their professional standing?

The doctors have decided on divorce. In Canada, control over medical practice is in the hands of the College of Physicians and Surgeons of each province. In Quebec, fees and collective bargaining are in the hands of physicians' unions.

To summarize, the following questions have been raised and would appear to be good material for discussion.

- Should nurses take a greater interest in hospital corporations and participate in them more frequently and in greater numbers?
- Should the director of nursing enjoy the same privileges and prerogatives as the medical director, including a seat on the board of management, and on the executive committee of the medical board with the right to be present, if not to vote, at meetings of this board?
- Could nurses be invited, at least occasionally, to membership on the board of management?
- Could nurses in a given hospital be organized in such a way that they might have a representative on the board of management?
- Could the control of nursing be placed in the hands of nurses, if so organized, with representation from medical personnel?
- Is there a place for some sort of system of appeal when the competence of a nurse is questioned, or when the value of a specific nursing procedure is disputed?

A lay person cannot settle these questions for nurses. However, if nurses themselves do not take the initiative, others will do so for them. In the name of the patient, mind your own business, but for goodness' sake, *do* mind it! □

Translated and adapted from an article that appeared in the May issue of *L'infirmière canadienne.*

research abstracts

Smith, Dorothy (McPhail), *Survey of follow-up of visual defects in grade one school children in central Alberta health units. 1958-59.* Ann Arbor, Mich., 1960. Thesis (M.P.H.) University of Michigan.

The investigation was confined to the possible influence of the attendance of a parent at the physical examination and of the size of the family upon the correction of referrable visual defects among grade one school children in three central Alberta health units.

The investigation showed that the correction of visual defects among grade one school children was not significantly influenced either by the attendance of the parent at the physical examination, or by the size of the family. One wonders, therefore, whether other factors, such as the socio-economic status of the family, the content of the interview with parents at the time of the physical examination, or the frequency and method of follow-up might have some bearing on the correction of visual defects.

A significantly higher percentage of school children had referrable visual defects corrected in a city of approximately 15,000 people than among those in a rural health unit where there was no center of population over 6,000 people. This distinct difference might suggest that the proximity of facilities for ophthalmic advice may have been an important factor in determining parental response to a recommendation for referral.

Flaherty, M. Josephine, *The prediction of college level academic achievement in adult extension students.* Toronto, 1968. Thesis (Ph.D.) Univ. of Toronto.

The purpose of the study was to identify factors – cognitive and non-cognitive – that account for the common variance among 43 psychological and biographical measures on adult college students, and to assess the relative importance of each factor for predicting academic achievement. Psychological variables included measures of verbal and non-verbal intellectual ability, intellectual speed, persistence, as well as orientations toward learning, study habits, and attitudes toward study. Biographical variables included data on age, number of years since leaving school, number of college subjects taken to date, and number of hours of study per week.

The first-order cognitive factors hypothesized to underlie the 43 measures were the fluid and crystallized general intellectual factors of Cattell. The non-cognitive factors that were expected included five orientation factors: learning orientation, sociability, personal goal, societal goal and need fulfillment, a study habits factor and an age factor.

Subjects for the study were 296 mature (adult) students enrolled in credit courses in the Division of Extension of a large metropolitan university. Analyses of data were carried out separately for three groups: the total group, males only, and females only. Analyses were done also on similar sub-groupings of students for whom high school grades were available. An iterative factor analysis was performed for each group of students and 12 first-order orthogonal factors were extracted. An oblique rotation was applied to the factor structure and, from the matrix of intercorrelations of first-order factors, second-order factors were extracted.

The obtained first-order cognitive factors were intellectual-educational ability, non-verbal reasoning ability, and intellectual speed. Non-cognitive factors included six orientation factors – learning orientation, sociability, societal goal, personal goal, need for acceptance by others, and relief from boredom-frustration. An age factor and a factor that was not named were also obtained for each group. A study habits and attitudes factor was obtained for all groups except females; for one group of females, an educational achievement factor was obtained.

At the second order, there was a general intellectual factor and three factors representing the learning, activity, and goal orientations. A fifth second-order factor, obtained for one group of females, was interpreted tentatively as educational orientation.

The results of the factor analysis did not provide evidence to distinguish the Cattell-Horn theory of fluid and crystallized intellectual abilities from Vernon's hierarchical model of abilities; this suggests that the two theories are not necessarily dissimilar as they apply to the behavior of adults. The findings did support an earlier conclusion that adults can be classified according to their orientations toward learning. It is suggested that further investigation be made of adult orientations toward learning, and, in particular, the two need-related orientations that were not identified in earlier studies.

To determine which factors best predict university performance, scores on the 12 orthogonal factors were computed for each student and used in a multiple regression analysis. Criteria for prediction were overall numerical grade average, and final grades in language, science, mathematics, humanities, and social science courses.

The intellectual-educational ability factor was the most effective predictor of overall grade average, science and social science grades, and made substantial contributions to the prediction of grades in humanities and languages; statistically significant contributions of this factor to the total criterion variance ranged from 3 percent to 18.87 percent. Study habits and attitudes were the most effective predictors of grades in the humanities (contributing from 7.35 to 22.44 percent of the total variance) and made large contributions to variance (ranging from 2.35 to 9.51 percent) in grade average, languages, and social science grades.

Need for acceptance by others was a useful predictor of humanities grades for females (10.07 to 10.54 percent of the variance), and made contributions, ranging from 1.58 to 5.29 percent of criterion variance, to prediction of grade average, humanities, social science, and science grades for other groups. Age made useful contributions to the prediction of science (3.50 to 5.80 percent) and mathematics grades (3.77 to 7.65 percent) for males and for the mixed groups. Societal goal orientation (6.18 to 15.07 percent) and non-verbal reasoning (3.81 to 10.23 percent) were the most effective predictors of mathematics grades. All the other orientation factors made substantial contributions to the prediction of grades.

The multiple regression analyses indicate that although the intellectual-educational factor was the best predictor of overall grade average, non-cognitive factors made substantial and sometimes larger contributions to the prediction of grades in specific course areas. There was evidence of marked differences in the predictive validity of some factors for males and females. It is suggested that prediction of academic achievement be done separately for males and females and that further investigation be carried out to determine the usefulness of non-cognitive factors in the prediction of academic achievement in adults. □

books

The Psychology of Play by Susanna Millar. 288 pages. Don Mills, Longmans Canada Limited, Penguin Division, 1968.
Reviewed by Elinor Burwell, Assistant Professor, Dept. of Psychology, Carleton University, Ottawa, Ont.

The subject of play has been treated by the author, a psychologist, in a thorough, scholarly fashion. Dr. Millar states that her book is intended mainly for the general reader, and that she has tried to present her material at a level that will be readily comprehended by non-psychologists. The scholar who is interested in play will not be displeased with this book, however.

Over 400 references to scientific books and journal articles are given in the bibliography; many were published as recently as 1967. Findings from observational and experimental studies are skilfully integrated, gaps in our knowledge are pointed out, and questions that require further exploration are brought to our attention.

There are two chapters on theories about play; theorists from Plato to Piaget are presented. The third chapter surveys, with many examples, the play of animals at various positions in the evolutionary scale. The remainder of the book deals with the variety of forms of children's play: exploring and movement play, phantasy and make-believe play, imitative play, social play. There is a thorough discussion of the influence on play of a number of individual difference variables: sex, intelligence, social class, culture. There is even a chapter on play therapy!

Dr. Millar writes in a clear, lucid style. This reviewer found the book highly readable and fascinating. However, the statement in the editorial foreword that the book "can be commended to all parents and to teachers as well as to students engaged in advanced studies in psychology and the social sciences" should be taken with a grain of salt. In the reviewer's opinion, the reader with no background in psychology will find parts of this book tough sledding.

Human Labor & Birth, 2nd ed. by Harry Oxorn and William R. Foote. 538 pages. New York, Appleton-Century-Crofts, 1968.
Reviewed by Phyllis Van Troyen, Inservice Director, and Sharon Benko, Head Nurse, Obstetrics, St. Mary's Hospital, Camrose, Alberta.

This text is an excellent handbook for obstetrical nurses and doctors. The information is presented in a concise point-form manner. Diagrams are in close proximity to the information. In this way the reader can use them as visual aids to the written information without having to refer to another part of the book. They are excellent in content, especially those describing position and presentation of the fetus.

The emphasis of the book is on anatomy and the practical application of obstetrics in labor and delivery. This is a refreshing change from most textbooks, in which the main concern seems to be physiology and psychology.

The information presented in point form permits the reader to find exactly what he is looking for without wading through reams of irrelevant words. A good background knowledge of obstetrics is required, but the book does provide an excellent source for reference and guidance to obstetrical personnel. This book should be kept close at hand on every obstetrical unit.

Fundamentals of Biostatistics by Stanley S. Schor. 312 pages. New York, G.P. Putnam's Sons, 1968. Canadian agent: Macmillan Co. of Canada Limited, Toronto.
Reviewed by Vivian Wood, Assistant Professor, School of Nursing, The University of Western Ontario, London, Ont.

This text, directed toward the clinical investigator, medical student and physician, begins with a general discussion of statistics. The clinical trial, an experiment designed to assess the value of a particular treatment, is examined in the second chapter. Other techniques and concepts, such as the double-blind study, the placebo effect and systematic versus experimental error, are included here.

The author then explores the design of the epidemiological study, which is usually a retrospective analysis of certain characteristics in selected populations. Examination and discussion of descriptive measures, probability, random sampling, and statistical inference follow in separate chapters. Both types of studies, the clinical trial and the experimental study, are completed with a discussion of the meanings and limitations of their results. Following a comprehensive examination of correlations and multiple sample tests, the author explores the use of non-parametric statistics and illustrates their use.

The last chapter discusses the Bayesian Theory of selecting the alternative that gives the greatest expected gain or smallest expected loss.

This text is written clearly, with summary statements and problems concluding each chapter. It would be useful, however, for students to have the answers either at the end of the text or in a supplemental workbook. Another minor fault is the repetition of previously described basic concepts.

This text could be used for courses in medical statistics and fundamentals of biostatistics.

The Pharmacologic Basis of Patient Care by Mary Kaye Asperheim. 417 pages. Toronto, W.B. Saunders, 1968.
Reviewed by Beth Davis, Assistant Supervisor, Inservice Education, Obstetrics, Kingston General Hospital, Kingston, Ont.

This book gives an excellent discussion of how drugs are administered, the effects they have on the body, and the nurse's responsibility to her patient.

The author introduces pharmacologic patient care by defining pharmacology, briefly describing the source of drugs, and explaining the various forms of these drugs. Also important is the interesting detail on Canadian and American legislation regarding all drugs and narcotics and the dispensing of these drugs.

The chapters on the mathematics of drug therapy, the administration of drugs, and the action of drugs on the body follow the introduction. The author then goes into detail about vitamins and minerals, antihistamines and immunizing agents, anti-neoplastic agents, radioactive drugs, and drug addiction. Each body system is dealt with separately. The author describes the system briefly, sometimes with the help of informative diagrams; she then discusses the drugs that affect each particular system.

In writing about drugs, the author uses both the generic and trade name and gives detailed but brief information about the

(Continued on page 52)

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books

(Continued from page 50)

drug, its uses, toxicity, and dosage.

In the table of contents, chapter headings are arranged according to parts of the body. For example, one chapter is on drugs that affect the respiratory center; another is on diagnostic agents. Each chapter is introduced by a brief preview of the important concepts to be discussed and ends with a few pertinent questions for review.

The index, consisting of 21 pages, makes it possible to find specific detail.

Because of the format used by the author, the book could be useful to instructors as well as to students; however, it would not be too useful for quick reference.

Social Competence & Mental Handicap — An Introduction To Social Education by H.C. Gunzburg. 225 pages. London, Bailliere, Tindall & Cassell, 1968. Canadian Agent: Macmillan Co. of Canada, Toronto.

Reviewed by Mary Macaulay, Director, Social Work Department, Rideau Regional Hospital School, Smiths Falls, Ont.

This book should be of great interest and help to those engaged in education and rehabilitation of the retarded.

Dr. Gunzburg speaks with authority and understanding. His approach to the assessment, evaluation, and development of social skills in the mentally retarded is thoroughly practical. He groups social skills under four sections: self-help, communication, socialization, and occupation. Each of these contains sub-sections referring to particular areas of social development.

1. Self-help includes skills such as good table habits, mobility, good toilet habits, washing, dressing, use of clothing, and personal health.

2. Communication includes all abilities relating to the use and understanding of the ordinary means of communication (language, reading, writing, and arithmetical work).

3. Socialization deals with the skills and ability to work *with* others, not just *next* to others.

4. Occupation refers to the skills that make a person useful, help to occupy him, and enable him to contribute to his own support. The training for occupation begins early, with the development of motor skills that are learned in a variety of ways, and which give a certain degree of physical competence for work tasks.

Dr. Gunzburg discusses the place of the Intelligence Quotient and the Social Quotient, and emphasizes that these two alone do not complete the assessment necessary for programming for the development of social skills. It is important to note the retardate who falls below others who are similar to himself, but have developed a higher degree of social competence than he has. In other words, take a look at the "retarded retardate" and find out what he needs to plan a better way of functioning for him. The assessment and planning will, hopefully, provide the child or adult with the "intellectual vitamins" he needs.

Dr. Gunzburg refers to the socially incompetent retardate as a "stranger in his own country," because he is often "ignorant of its customs, imperfect in his command of the language, deficient in his understanding, suspicious of the intentions of others, and bewildered by the demands of changing situations." He suggests a first aid program for him in the areas already mentioned.

The case for systematic observation and assessment is very strong, because Dr. Gunzburg sees the retarded as an individual with special needs, rather than a problem case to be measured. With help such as he prescribes, the retardate may be "at home" rather than a "stranger" in his own country.

Nutrition and Diet Therapy by Sue Rodwell Williams. 686 pages. Saint Louis, Mosby, 1969.

Reviewed by S.J. Slinger, Professor and Chairman, Department of Nutrition, Ontario Agricultural College, Guelph, Ont.

The author is well qualified to write this text, and obviously is dedicated to the field of nutrition in health and disease. The book is easy to read, well organized, and presents a wealth of up-to-date information of value to the nurse in any area of work.

The first several chapters deal with the foundations of nutrition, including the roles of the various broad classes of nutrients, the importance of water and electrolytes, and digestion, absorption, and metabolism. In these chapters the author places nutrition on a chemical basis and relates the nutritive needs in terms of basic chemical compounds rather than in terms of food. Great care is taken, however, to show how the individual nutrients are interrelated for the total physical and psychological needs of the individual. With this background the student is in a position to understand the applied chapters that follow.

The section on applied nutrition presents valuable information on the dangers of food faddism, the necessity and means of protecting the community food supply, and the methods of teaching nutrition to the community and the family.

The section on nutrition in nursing emphasizes such areas as nutrition during pregnancy and lactation, during various stages of the life cycle, in rehabilitation, the importance of nutrition in relation to psychiatric nursing, and nutritional therapy in disease.

Also of particular interest is the section on nutrition in medical-surgical nursing, which describes in detail the application of sound nutrition principles to the care of patients with specific diseases.

The presentation of glossaries of terms and useful questions throughout the book will be of considerable value to the student. A large number of references that are also included will help the interested student enrich her knowledge.

The science of nutrition is in a continuous state of flux, with new information being uncovered at a rapid rate. The nurse must have an adequate understanding of this science if she is to fulfil her obligations to the patient and the public at large. This book is recommended not only to the nurse, but to all other persons concerned with health and disease as they relate to nutrition.

Correction

In the February "Books" section, *Health Services Administration: Policy Cases and the Case Method,* edited by Roy Penchansky, was listed as a publication of Harvard University Press. The Canadian distributor is Saunders of Toronto, 1885 Leslie St., Don Mills, Ont. Saunders of Toronto also distributes *Infectious Diseases,* by Dauer, Korns, and Schuman, which was incorrectly listed as a W.B. Saunders publication in the June issue of CNJ.

Principles of Medicine, 4th ed. by James Verney Cable. 685 pages. Christchurch, New Zealand, N.M. Peryer Limited, 1969.

Reviewed by Irene MacMillan, Assistant Director of Nursing, Montreal Neurological Hospital, Montreal, Que.

The author recognizes the contribution of the nurse to the total care of the patient, and shares with her his knowledge to help make the treatment of the patient more meaningful. He draws on such related disciplines as pharmacology, bacteriology, and psychology to present a comprehensive study of the conditions discussed.

His clear-cut style simplifies the extremely complex subjects. Examples are frequent and specific, illustrations are helpful, cross references are generously used, and excellent summaries are provided.

The result is a book that is particularly useful to the student as an outline to

books

consolidate information received from other courses and from experience; to the graduate nurse who has elected to specialize in one type of nursing but who wishes to keep abreast of new developments in medicine as a whole; and to lay readers who will appreciate its readable style and the general information presented. Although prepared especially for nurses in New Zealand, the book should prove to be a valuable addition to any nursing library.

The Young Handicapped Child, 2nd ed.,by Agatha H. Bowley and Leslie Gardner. 167 pages. Edinburgh and London, E. & S. Livingstone Ltd., 1969. Canadian Agent: Macmillan Co. of Canada, Toronto.

Reviewed by Dr. Helen Evans Reid, Dept. of Medical Publications, The Hospital for Sick Children, Toronto, Ont.

This book deals with four types of handicaps: cerebral palsy, deafness, blindness, and autism. The authors discuss recognition of the handicap and outline the problems involved in the care and education of children who have these handicaps.

Agencies that provide assistance for handicapped children are listed at the end of each chapter, although those referred to are in Britain.

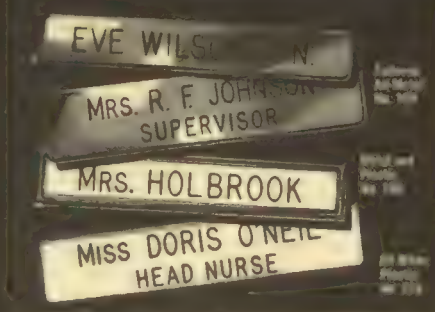
This book is recommended for health care workers, including social workers and nurses, and specialist teachers of the handicapped. It is less suitable for parents who might find the discussion of other conditions too discouraging.

Pediatric Surgery for Nurses, edited by John G. Raffensperger and Rosellen Bohlen Primrose. 327 pages. Boston, Little, Brown and Company, 1968. Canadian agent: J.B. Lippincott Co. of Canada, Toronto.

Reviewed by Roselyn Smith, Director of Nursing, Montreal Children's Hospital, Montreal, P.Q.

With the recent advances in pediatric medicine and the stress on prevention, many of the children's conditions requiring medical treatment have practically disappeared. At the same time, advances in surgery are now able to save children who would not have survived because of congenital anomalies, disease, trauma, and malignancies. As surgery advances, surgical nursing must keep pace. To date, pediatric surgical nursing textbooks have been few and the need for them is great.

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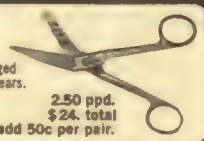
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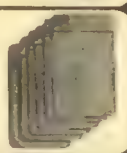
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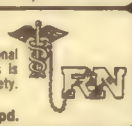
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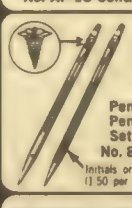


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This reviewer is particularly impressed with the breadth of approach to pediatric surgical nursing in this volume. The text deals with most pediatric surgical problems that nurses see in hospitals. Pre- and postoperative care are discussed and many of the illustrations are most helpful.

Emphasis is placed on the role of the nurse in the pediatric surgical team and on the kinds of situations in which she must take knowledgeable and prompt, independent action.

Such areas as the newborn infant, trauma, and malignancies are well covered. The book also deals with such specialties as neurosurgery, orthopedics, plastics, and cardiac surgery, as well as abdominal, eye, ear, nose and throat surgery, and surgery of the genitourinary tract.

Of note throughout the text is the comprehensive approach to the needs of the child and his family. The section on burns recognizes the effect of nursing this type of injury on morale of the staff and makes useful suggestions.

At the end of each section, pertinent nursing care problems are posed and some answers to these problems are provided at the back of the book.

The text is concise, easy to read, and should be useful to nurses at all levels. It would be a valuable addition to any ward library. □

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BOOKS AND DOCUMENTS

1. *American Association of Junior Colleges. Junior college directory*, Washington, American Association of Junior Colleges, 1969. 109p. R

2. *Bases et limites physiologiques du contrôle des naissances* par C. Thibault et M. C. Levasseur. Paris, Doin, 1968. 110p.

3. *Basic microbiology* by Margaret F. Wheeler and Westley A. Volk. Philadelphia, Lippincott, c1969. 410p.

4. *Canadian Hospital Association office and association directory.* Toronto, Canadian Hospital Association, 1969. 47p. R

5. *The construction and use of teacher-made tests* by Mary R. Shields. 2d ed. New York, National League for Nursing, Test Construction Unit, 1965. 116p. (The Use of Tests in Schools of Nursing, pamphlet no. 5)

6. *Educational television and radio in Britain;* present provisions and future possibilities. Papers prepared for a national conference organized jointly by the BBC and the University of Sussex and held at the Conference Centre, the White House, Chelwood Gate, Sussex 13 to 17 May 1966. London, c1966. 292p.

7. *Exposés schématiques de soins pré et postopératoires* par Claude Bomet. Paris, Maloine, 1965. 287p.

8. *Forces affecting nursing practice* edited by Dorothy D. Petrowski and Margaret T. Partheymuller. Washington, Catholic University of America Press, c1969. 117p.

9. *Fundamentals of nursing; the humanities and the sciences in nursing* by Elinor V. Fuerst and LuVerne Wolff. 4th ed. Philadelphia, Lippincott, c1969. 446p.

10. *Fundamental skills in the nurse-patient*



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relationship; a programmed text by Lianne S. Mercer and Patricia O'Connor. Philadelphia, Saunders, c1969. 192p.

11. *A guide for the development of refresher courses for professional nurses* by Rachel B. Westmoreland and Kenneth S. Oleson. Raleigh, Dept. of Community Colleges, State Board of Education, 1967. 1v. (various paging).

12. *A guide for health technology program planning* by American Association of Junior Colleges and National Health Council, 1967. 52p.

13. *Health manpower; factors of crisis.* North Miami, Fla., North Miami General Hospital; reprinted from Medical Tribune, New York, N.Y., March-July 1968, c1968. 78p.

14. *Health service delivery to the community.* Papers presented at the Council of Hospital and Related Institutional Services, October 10-11, 1968, Dallas, Texas. New York, National League for Nursing, 1969. 58p.

15. *The hospitals yearbook and directory of hospital suppliers, 1969.* London, Institute of Hospital Administrators, 1969. 1384p. R

16. *How to make money writing short articles and fillers* by Marjorie M. Hinds. New York, Fell, c1968. 127p.

17. *An introduction to the physical aspects of nursing science* by O.F.G. Kilgour. London, William Heinemann, c1969. 292p.

18. *Job descriptions: how to write and use them* by Conrad Berenson and Henry O. Ruhnke. 1969 ed. Swarthmore, Personnel Journal, 1969. 45p.

19. *Measuring faculty performance* by Arthur Cohen and Florence B. Brawer. Washington, American Association of Junior Colleges, 1969. 81p.

20. *Medical-surgical nursing workbook for practical nurses* by Dorothy F. Johnston. 2d ed., Saint Louis, Mo., Mosby, 1969. 146p.

21. *Microbiology in health and disease* by Martin Frobisher, Lucile Sommermeyer and Robert Fuerst. 12th ed. Philadelphia, Saunders, 1969. 549p.

22. *Nursing of children: a guide for study* by Debra P. Hymovick. Philadelphia, Saunders, c1969. 389p.

23. *Pédiatrie* par M. Poitout et C. Joly. Paris, Maloine, 1967. 432p.

24. *Preparation for retirement* by Woodrow W. Hunter. Ann Arbor, Mich., Division of Gerontology, University of Michigan, 1968. 108p.

25. *Proceedings of ANA Conference for Members and Professional Employees of State Boards of Nursing and ANA Advisory Council, Dallas, Texas, May 9-10, 1968.* New York, American Nurses' Association, 1969. 46p.

26. *Social policies for Canada, part 1.* Ottawa, Canadian Welfare Council, 1969. 78 p.

27. *State approved school of professional nursing, 1969.* New York, National League for Nursing. Research and Studies Services. 112p.

28. *A study of 1543 women 21 years of age and over at the University of Manitoba, September 1967–May 1968* by Shirley A. Smith, Winnipeg, University of Manitoba, 1968. 70p.

29. *Work attitudes and retirement adjustment* by Jean E. Draper, Earl F. Lundgren and George B. Strother. Madison, Univ. of Wisconsin, Graduate School of Business, Bureau of Business Research and Service, 1967. 91p.

30. *Workbook for maternity nursing* by Constance Lerch. 2d ed. Saint Louis, Mosby, c1969. 303p.

PAMPHLETS

31. *ARNN, what it is, what it does.* St. John's, Association of Registered Nurses of Newfoundland, 1969. 15p.

32. *Esquisses; l'Hôtel-Dieu de Québec.* Québec, P.Q., 1939. 1v. (not paged) R

33. *Guidelines for the development of post-basic education for nurses.* Geneva, World Health Organization, 1969. 17p.

34. *A national occupational health service* by Royal College of Nursing and National Council of the United Kingdom. London, 1969. 15p.

35. *On using and being a consultant.* Washington, American Associations of Junior Colleges, c1967. 33p.

36. *Organization of University Health Centre Administrators* by John F. McCreary. Vancouver, British Columbia, 1968. 11p.

37. *Principles of organization, management and community relations for hospitals.* Chicago, American Hospital Association, c1964. 13p.

38. *Public health nursing activity study;* report to the CPHA (Alberta Division) Convention 1969 by Beryl Ebert. Edmonton, 1969. 11p.

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39. *Rounded development of the human personality* by F.F. Koroler. Toronto, Convergence, 1968. 5p.

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40. Bureau of Statistics. *Salaries and qualifications of teachers in universities and colleges, 1967-68.* Ottawa, Queen's Printer, 1969. 75p.

41. Dept. of Finance. *Canada student loans plan, report, 1965-1967.* Ottawa, Queen's Printer, 1969. 3v.

42. Dept. of Labour. *Canada and the International Labour Organization; 50 years of social progress.* Ottawa, 1968. 1v. (various pagings).

43. ———. *Labour and industrial relations research in Canada:* progress report, December 1968. Ottawa, Queen's Printer, 1969. 32p.

44 ———. *Report 1968.* Ottawa, Queen's Printer, 1969. 58p.

45. ———. Women's Bureau and Economics and Research Branch. *Maternity leave policies; a survey.* Ottawa, Queen's Printer, 1969. 137p.

46. Dept. of National Health and Welfare. *Canada Assistance Plan, report, 1966-67.* Ottawa, 1968. 1v.

47. ———. Emergency Welfare Services Division. *Emergency clothing operations.* Ottawa, Queen's Printer, 1969. 82p.

48. ———. Division de l'hygiène dentaire. *Manuel d'hygiène dentaire.* Ottawa, 1969. 48p.

49. Ministère de la Santé nationale et du bien-être social. *Rapport, 1967.* Ottawa, Imprimeur de la Reine, 1968. 279p.

50. National Science Library. *Scientific and technical societies of Canada.* Ottawa, National Research Council of Canada, 1968. 69p. R

Ontario

51. Dept. of Labour. Research Branch. *Negotiated wage rates in Ontario hospitals,* March 1969. Toronto, 1969. 98p.

52. Provincial Committee on Aims and Objectives of Education in the schools of Ontario. *Living and learning; the report of the Provincial Committee . . .* Toronto, Ontario, Department of Education, 1968. 221p.

Quebec

53. Gouvernement. Ministère de l'Education. *Direction générale de l'enseignement collégial.* Québec, 1968. 28p.

USA

54. Bureau of Labor Statistics. Middle Atlantic Region. *Some facts relating to changing patterns of costs and structure in the health sector* by Hubert Bienstock. New York, 1969. 12p.

55. Dept. of Health, Education and Welfare. National Institutes of Health. *Pain.* Washington, U.S. Govt. Print. Off. 1968. 16p.

STUDIES DEPOSITED IN CNA REPOSITORY COLLECTION

56. Care approaches to the dying patient and his family *by Michelle Marion Brideau. London, 1968. 61p.* R

57. *Continuing education for nurses;* a study of the need for continuing education for registered nurses in Ontario by School of Nursing, University of Toronto and Division of University Extension. Toronto, 1969. 63p. R

58. *Correlates of approval and disapproval received by students at selected schools of nursing* by Margaret L. Hayward. Pittsburg, 1969. 119p. (Thesis – Pittsburg) R

59. *Family doctor, public health nurse teamwork, a report of a study* by Phyllis E. Jones. Toronto, School of Nursing, University of Toronto, 1969. 58p. R

60. *A guide for the public health nurse to assist elderly patients in the achievement of selected functional tasks at home* by Phyllis Margaret (Baird) Wilson. Seattle, Wash. 1968. 96p. (Thesis (M.N.) – Washington) R

61. *Guilt: an operationally defined concept* by Pauline Annette (Peters) Kliewer, Washington, 1969. 97p. (Thesis (M.A.) – Washington) R

62. *One year follow-up survey of the 1968 re-entry program for inactive registered nurses.* Halifax, Registered Nurses Association of Nova Scotia, 1969. 8p. R

63. *A study of the activities of nursing personnel in ten health units and one city health department in the province of Alberta.* Edmonton, Dept. of Health, Alberta. 1968. 40p. R

64. *Supervisor activities and the clinical specialist* by Sister Carmen Wolfe and Marcie M. Richmond. Boston, 1969. 44p. (Thesis (M.Sc.N) – Boston) R

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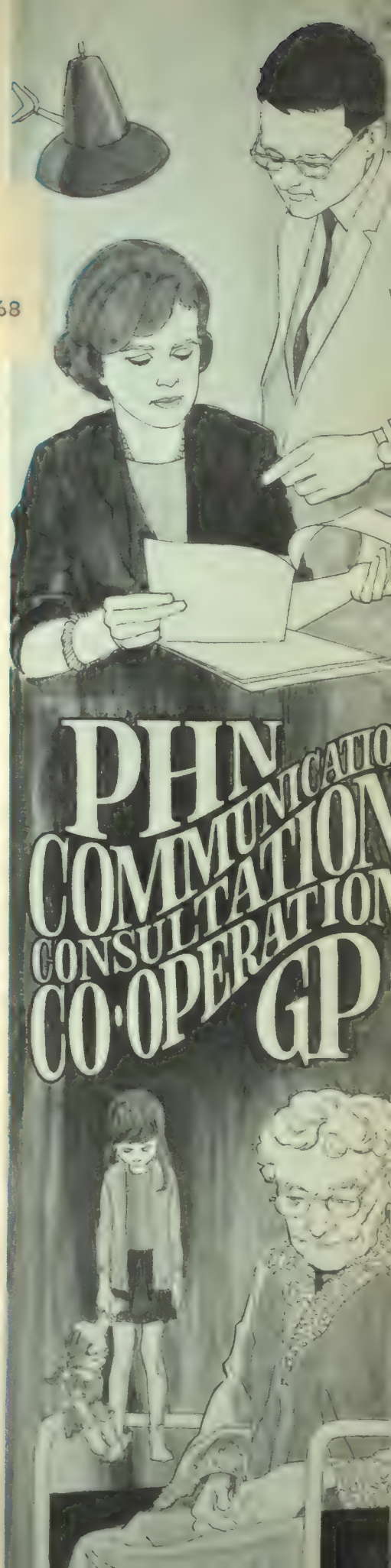
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The views expressed in the various articles are the views of the authors and do not necessarily represent the policies or views of the Canadian Nurses' Association.

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We're not wagging our editorial fingers at anyone this month. For one thing, it's summer as we write this and – well, you know the feeling one gets two days before vacation. Beside – and more to the point – those non-wagging fingers have poison ivy on them. Yes, POISON IVY.

Now we know, dear readers, that there are those among you who undoubtedly will say "It serves those fingers right! They deserve to suffer from this type of Rhus dermatitis. Long may they itch! " Others, of course, will "tut tut" in sympathy – or empathy, as you will – recalling with less than nostalgia their own experiences with this three-leafed monster. Still others will ask, "How could anyone be so stupid . . .? "

Well, it was like this. We (not the entire staff, just the "editorial we") recently tip-toed through a juicy patch of this vermin of the plant kingdom, assuming that we were *immune.* How the malady got from bottom digits to top digits is anyone's guess.

Believing in the theory that one should make the best of a bad "learning experience," we did a little research on the subject, which we hereby present for your future safety. Now research is difficult at the best of times. But when one is forced to rely on only the unaffected parts of one's body – namely the eyes – it can be extremely frustrating. So we know you will overlook any overgeneralizations in our conclusion.

First – and get this – poison ivy isn't really poison ivy at all. It's *Toxicodendron radicans.* Had we known that, we'd have given it a much wider berth.

Second, *TR* grows in every province but Newfoundland. The Newfies probably shooed it off to the mainland by spraying it with Screech.

Third, only 10 percent of persons who have had this disease retain their immunity to it. (It's a blow to one's pride to know that one belongs with 90 percent of the population).

Fourth, and last, the treatment for relief of the discomfort is the same today as it was 30 years ago: good old Calamine lotion.

Well, as the boys in the backwoods say, "Leaves three – let it be."

V.A.L.

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Lobbyist needed

I was very pleased and excited to read the editorial "Needed: A Full-Time Lobbyist" (July, 1969). I endorse your proposal wholeheartedly.

We have witnessed tremendous changes and advances in many areas of nursing in recent years, but in other areas nursing has barely progressed beyond the early evolutionary stages.

Government relations officers must and will become a reality. The question is, when?

I would be grateful to receive any further information on this matter, including preparation, qualifications and requirements of such a lobbyist should the position ever be created. – Margaret Becker, Reg. N., B.N.Sc.:

I would like to express my support for the idea of the Canadian Nurses' Association having a lobbyist as a bridge between the association and the federal government.

We do not generally hear about or from nurses in public reports, unless it is pertaining to extraordinary events such as a strike. What do the nurses working in public health among the Indians feel about new legislation concerning the future of the Indians? Are their views expressed to the committees dealing with the subject? What do nurses feel about the legislation that still allows lashing of prisoners in our jails? Laws such as these are as outdated as the hedonistic philosophy of the 18th century on which they are based.

I think nurses should be heard on subjects like these. Our concept of health must be broad and include social as well as physical, mental, and emotional interpretations. A lobbyist should let nurses' concerns be known to the legislators. If such a position is to be created, my application will probably be in the mail. – Dorothy Fulford, Ottawa, Ont.

I felt you might be interested in our response to your mini-editorial in the July issue of *The Canadian Nurse*. We were contacted by radio station CFNB, Fredericton, and I made the following statement on behalf of the New Brunswick Association of Registered Nurses.

"We would agree with the editor of *The Canadian Nurse* that there is a need for improved communication with government, both national and provincial. We believe that if there were a "government relations representative" nationally, a desirable result would be a better informed public. There is a need for a greater understanding of the services given by the actively employed Canadian nurses.

"All too often studies are done or boards set up to study some aspect of health care in Canada or one of our provinces, and nursing is not involved.

"We believe the recipient of health care is interested in the standards of care which is to be offered to him, but communication with government at national level would benefit government, the Canadian nurses, and most important each Canadian citizen." – M. Jean Anderson, B.S.R.N., Executive Secretary, NBARN.

In your editorial "Needed: a full-time lobbyist" you point out that the nursing profession is the largest health profession in Canada, and it is therefore extremely important that it be heard by government on matters concerning nurses, nursing, and health. A substantial budgetary allocation is now made toward health programs and services, and will likely continue to be made no matter what political party holds the power in Ottawa. As citizens, and as health professionals, nurses ought to help insure that political decisions on health-related matters are based upon information that is as accurate and as complete as possible.

A professional nursing association has a responsibility to serve the public interest with respect to nursing and matters related to nursing. Surely the Canadian Nurses' Association can only fulfill this responsibility if it makes available to government a tuned ear and an informed voice to identify matters of concern to nurses, and to provide to both government and opposition party members the data regarding health care, health needs and health resources that only nurses can provide. The tuned ear and the informed voice logically must belong to a professional nurse who fulfills the role of lobbyist or government relations representative. – Dorothy J. Kergin, Reg. N., Ph.D., associate professor, School of Nursing, McMaster University, Hamilton.

Two-year program

In reply to the letters (May, June, 1969) regarding the article "Two-Year Versus Three-Year Programs" (February, 1969), the faculty of the Grey Nuns' School of Nursing wish to indicate that we see merit in speaking with each other through *The Canadian Nurse*. Controversy is often an indication of professional growth, and on this basis we wish to utter our concerns about the concerns of the writers of these letters.

What do you, as researchers, consider an adequate theoretical rationale for review of literature?

Ratings of the two independent raters were consistent over a three-year period. The ratings of the two independent raters were not equivalent.

Regarding the design of the study having limitations, we wondered why you did not mention the obvious point that the two groups of students followed a revised curriculum, and that the conclusions might well have been different had the control group come from another school of nursing following a three-year, service-oriented program taught by different teachers. At no point was the statement of "superiority" of one group over another made.

That readers might have interpreted that the performance of the three-year students was significantly better than that of the two-year students would be an inference, as the summary statement made was that the control students performed generally better than the two-year students. We would anticipate that you, as researchers, would avoid the pitfall of making inferences or jumping to conclusions.

Since this study was done, the Grey Nuns' School of Nursing has improved the two-year program, phased out the three-year program, and will soon move into a multi-disciplinary post-secondary educational institution. – Faculty, Grey Nuns' School of Nursing, Regina, Sask.

New Brunswick resignations

I am concerned about the mass resignation of registered nurses employed by public hospitals in New Brunswick. The resignation becomes effective August 15, 1969, after three years of negotiations.

First, these nurses are making great personal sacrifices. They will be without pay and will face difficulty in financing a move and obtaining employment elsewhere. They have volunteered their services for emergency care, but they must take a stand to protect their profession and the patient, whom they serve.

Second, in some provinces, because of

(Continued on page 6)



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letters

(Continued from page 4)

existing labor laws, mass resignation is the final recourse nurses can use to improve their working conditions. The provincial associations representing registered nurses often cannot act on behalf of their members, resulting in many groups acting on their own behalf with their employing agency.

What can nurses who are genuinely committed to nursing do about poor working conditions, such as staff shortages, that threaten the safety of the patient, and exhaust and frustrate staff? Some employing agencies have allowed nurses' organizations within the agency to discuss working conditions, salaries, etc. But many will not.

If a recurrence of this situation is to be prevented, improved communication, understanding, and a review of existing labor laws are not only essential, but overdue! — Donna Roe, Ottawa, Ontario.

Diploma versus degree

The many fine articles in *The Canadian Nurse* are commendable. However, I question some of the proposals made by the university educated leaders.

Why should the new graduate of a university program receive $1,440 per year more than a new graduate from a diploma program? Is the university degree being used as a status goal?

Is the phasing out of programs for psychiatric nurses and nursing assistants not being proposed too soon? I cannot foresee the replacement of these valuable assistants by registered nurses or university graduates.

Two categories of nurses have been proposed: the university graduate and the registered nurse technician. Who will teach techniques? The university graduate has knowledge of theory, but is she proficient in the nursing arts?

Statistically speaking, university educated nurses are in a small minority, particularly those with advanced theoretical and practical knowledge. Is it not time to reassess the problem?

There is a human element involved too. The desires of the few should not be achieved by overlooking the needs of the many nurses who have struggled over the years against impossible barriers.

The nursing profession is showing the aspects of pride and prejudice originally reserved for the medical elite. Progress is fine, but let us not replace the doctor who considers the nurse his handmaiden by university educated nurses with similar delusions of grandeur. — Rita Carroll, R.N., Maxville, Ont. □



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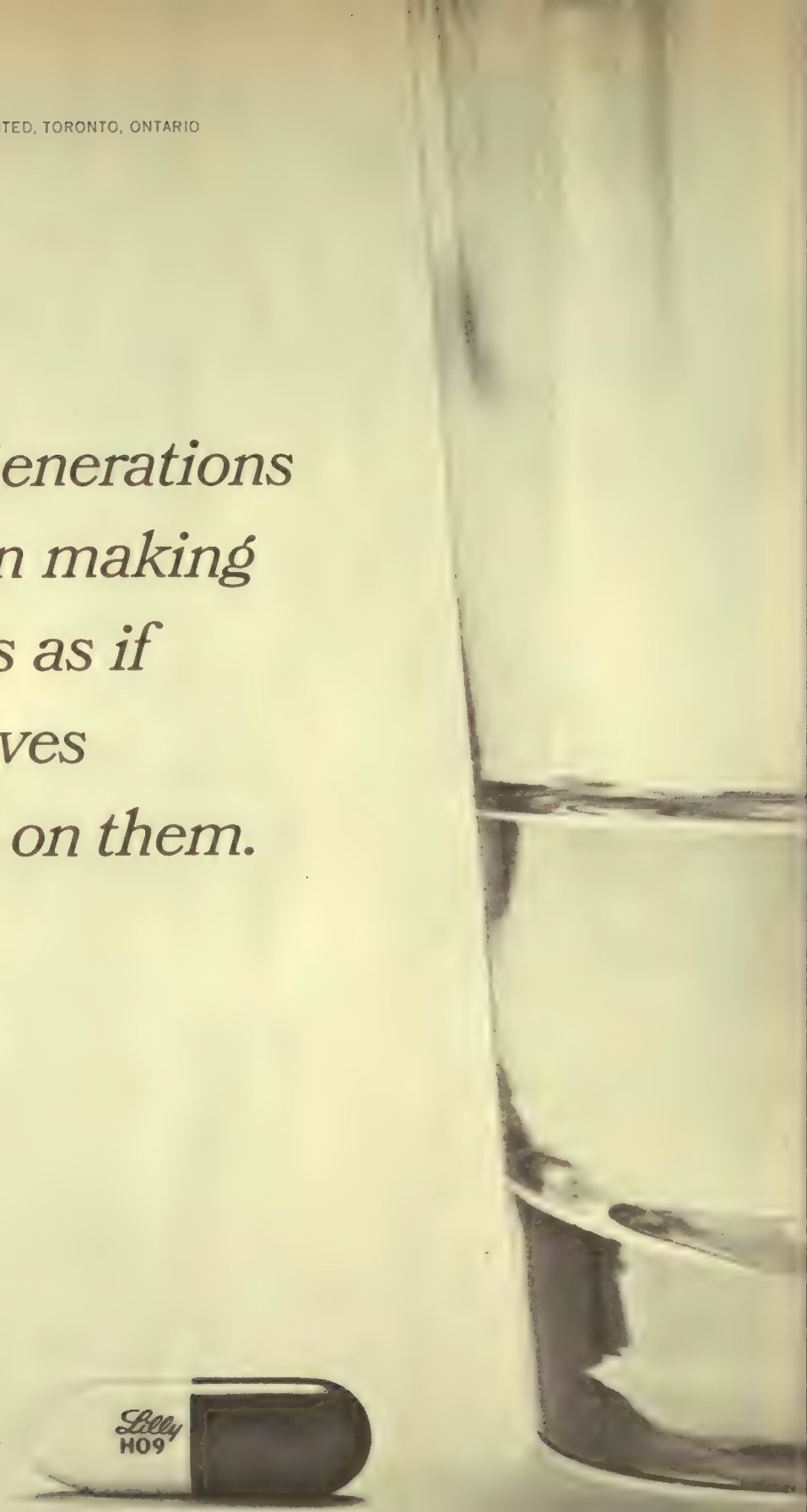
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news

CNF Announces Scholarship Winners

Ottawa. – The Canadian Nurses' Foundation has awarded $44,000 to 17 Canadian nurses to pursue graduate studies in the 1969-70 academic year.

Helen P. Glass of Winnipeg, Manitoba, assistant professor University of Manitoba School of Nursing since 1962, has been awarded the Dr. Katherine E. MacLaggan Fellowship of $4,000 to continue her study for a Doctor of Education degree at Teachers College, Columbia University, New York.

The 16 CNF awards to candidates for masters' degrees range from $1,300 to $3,000. The recipients, selected for their leadership potential as well as scholastic ability are:

- Mrs. Anita Cabelli of Montreal, Quebec, a fellowship to study for a Master of Science (A) degree in Nursing at McGill University, Montreal.
- Mrs. Teresa M. A. Davis of Edmonton, Alberta, a fellowship to study for a Master of Education degree at the University of Alberta.
- Miss Frances Howard of Saint John, New Brunswick, former nursing service consultant, Canadian Nurses' Association, a fellowship to study for a master's degree in nursing service administration at the University of Western Ontario, London, Ontario.
- Miss Hisako Rose Imai of Pierrefonds Quebec, a fellowship to study for a Master of Public Health degree at Johns Hopkins University, Baltimore, Maryland.
- Miss June Fumiko Kikuchi of Toronto, Ontario, a fellowship to study for a Master of Nursing Education degree at the University of Pittsburgh, Pittsburgh Pennsylvania.
- Mlle Rita J. M. Lussier of Laflèche, Quebec, a fellowship to study for a Master of Science degree in Nursing at Boston University, Boston, Massachusetts.
- Miss Kathleen R. Miller of Victoria, British Columbia, a fellowship to study for a Master of Science degree in Nursing at Yale University, New Haven, Connecticut.
- Miss T. Rose Murakami of Salt Spring Island, British Columbia, a fellowship to study for a Master of Science (A) degree in Nursing at McGill University, Montreal.
- Mrs. Margaret L. Mrazek of Edmonton, Alberta, a fellowship to study for a master's degree in health service administration.
- Miss Diana D. Pechiulis of Calgary, Alberta, a fellowship to study for a master's degree in nursing service administration or supervision at the University of Colorado, Denver, Colorado.
- Mr. Ronald S. Reighley of Red Deer Alberta, a fellowship to study for a Master of Science (A) degree in Nursing at McGill University, Montreal.
- Miss Marilyn S. Riley of Windsor, Nova Scotia, a fellowship to study for a Master of Science in Nursing degree at the University of Western Ontario, London, Ontario.
- Miss Judith A. Ritchie of Saint John, New Brunswick, a fellowship to study for a Master of Nursing degree at the University of Pittsburgh, Pittsburgh, Pennsylvania.
- Miss Sheila M. Ryan of Edmonton Alberta, a fellowship to study for a master's degree in health service administration at the University of Alberta, Edmonton, Alberta.
- Miss Julia E. Shannon of Vancouver, British Columbia, a fellowship to study for a Master of Science degree in Nursing at the University of Michigan, Ann Arbor Michigan.
- Mrs. Ethel M. Smith of Vancouver, British Columbia, has been awarded the W.B. Saunders Company Canada Fellowship and a CNF fellowship to study for a Master of Science in nursing degree at the University of British Columbia, Vancouver, British Columbia.

Federal Government Contribution To ICN Congress

The federal government informed the Canadian Nurses' Association in May, 1969, that it would contribute $25,000 toward the costs of the International Council of Nurses' 14th Quadrennial Congress held in June. This amount was allocated "... to assist with the translation service so as to permit Canadian nurses to benefit from all the presentations at the Congress.'

This information was received by *The Canadian Nurse* early in June, but was inadvertently omitted. The editor regrets this omission.

Health Manpower Conference To Be Held In Ottawa

Ottawa. – Some 200 representatives of the health and health-related professions will meet in Ottawa October 7 to 10 at a national health manpower conference.

The conference will be sponsored jointly by the Department of National Health and Welfare and the Association of Universities and Colleges of Canada. It will bring together persons familiar with the problems that exist in the health services field to formulate suggestions for a program to improve the human resources of Canada in the health and health related fields. Papers will be presented on several topics, including society's health expectations, planning and delivery of comprehensive health services, and educational trends and objectives. Panel discussions will be held throughout the four-day conference, and during two days participants will discuss specific topics in dis-

Présence



The history of Canadian nursing was given some extra publicity in June when *Présence,* the French edition of the Canadian Nurses' Association's *The Leaf and the Lamp,* was published. Shown here by Agathe Legault, assistant editor of *L'infirmière canadienne,* the book was translated by Madeleine Wermenlinger-DeRopero, and is available for $3.00 on request from CNA, 50 The Driveway, Ottawa, Ontario.

cussion groups of smaller numbers.

Conference planners hope agreement can be reached on guidelines for: planning the delivery of total health services during the next decade; determining the numbers and quality of health manpower required for these services; and planning the education of the required manpower.

"This National Health Manpower Conference will be the first of its kind to be held in Canada," the Honorable John Munro, minister of national health and welfare, explained. "We hope that this conference will aid in the attainment of the goal of equality in health care for all Canadians."

Co-chairmen of the conference are Jacques Gelinas, deputy minister of health for the province of Quebec, and Professor L.-P. Bonneau, vice rector of Laval University. Speakers include Mr. Munro; J.F. McCreary, dean of medicine at the University of British Columbia; Warren J. Perry, dean of the school of health related professions at the State University of New York; and others from various related professions.

Among the 12 panelists is Lois Graham-Cumming, director of research and advisory services for the Canadian Nurses' Association. CNA was among seven professional associations invited to participate in the conference.

ANPQ To Study Nursing Profession In Quebec

Montreal, P.Q. – Madeleine Jalbert, president of the Association of Nurses of the Province of Quebec, recently announced that the ANPQ is conducting a study to evaluate the nursing profession in the province.

Miss Jalbert told *L'infirmière canadienne* some of the reasons why the study was undertaken. "We have noticed that nurses are not involved in their professional association," she said, "and as a result chapter meetings are often a failure. Secondly, nursing must function within a rapidly changing society and we must adapt to meet new needs," she said.

To meet these needs the ANPQ has formed an ad hoc committee to conduct an opinion poll among nurses in Quebec. Moyra Allen, associate professor, School for Graduate Nurses, McGill University, and Jacqueline Gagnon-Audet, a member of the advisory committee of ANPQ, have been appointed to this ad hoc committee and will submit their report in 1970. Questionnaires have been distributed to ANPQ districts, to the general and vocational colleges, and to several individual nurses in Quebec.

The ANPQ has also obtained the services of "Cadres Professionnels Incorporés," a firm of consultants, to conduct a scientific study of the association's problems and to make an objective evaluation. From a sample population of nurses, the consultants – economists, psychologists, and sociologists – will survey their activities to determine, among other things, the image and role of the nurse in relation to the profession, the administrative structure of the hospital, and the public. Groups outside the nursing profession will be approached to determine how they view the role of the nurse as compared to other professionals.

Miss Jalbert said that the main purpose of a professional association is to establish good relationships among nurses and between nurses and the public. She said that the association has an obligation to protect the public by maintaining high educational standards for nurses and nursing service. To meet this obligation, good public relations and communication within the profession are needed, she said.

Greek Gift to CNA



The Hellenic Nurses' Association presented the bust of Hygeia to the Canadian Nurses' Association during the Congress of the International Council of Nurses in Montreal in June. Dr. Helen K. Mussallem (right), executive director of CNA, accepted the gift on behalf of the Association. The original Hygeia is housed in the Archeological Museum in Athens.

New Brunswick Nurses Withdraw Resignations

Fredericton, N.B. – One thousand four hundred New Brunswick hospital nurses have withdrawn their resignations. They had threatened to leave their jobs August 15 because of a contract dispute.

Negotiations between the New Brunswick Association of Registered Nurses and the New Brunswick Hospital Association resumed July 24 after the NBHA president approached the NBARN president for a "communications meeting."

"NBHA conceded to all our demands regarding procedure," said Marilyn Brewer, spokesman for the nurses. Among other things the NBHA has agreed to establish a committee to meet with the nurses, she explained. Previous negotiations had been unsuccessful because of constant changes in management representatives.

"If negotiations break down, both parties shall apply to the minister of labour to appoint a conciliation officer. If for any reason the above step does not resolve the deadlock, a three-member board of mediation will be established."

(Continued on page 13)



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(Continued from page 10)

Mrs. Brewer explained that the minister of health has guaranteed the cooperation of the minister of labour in this matter.

The NBHA also guaranteed that those nurses who submitted resignations would not be subject to any reprisals, Mrs. Brewer said.

Mrs. Brewer also said that the staff association presidents would meet at NBARN headquarters on August 12 to discuss the proposals of the new contract. At press time no information on contract terms was available.

Canadian Neuro Nurses Form Association

Montreal, P.Q. — A desire to improve communications among specialist nurses and to share and increase knowledge has prompted more than 40 nurses to organize a Canadian Association of Neurological and Neurosurgical Nurses. The organizational meeting was held at the Château Champlain hotel in Montreal on June 20.

Annual meetings will be arranged to coincide with the Canadian Congress of Neurological Sciences, an organization of physicians in that field. The nurses will meet at the same time and place.

Any nurse interested in neurological or neurosurgical nursing who wishes to join the nurses' association is invited to contact a member of the executive for more information.

Elected to the executive were: Jessie Young, Toronto General Hospital, chairman; Anne Carney, Montreal Neurological Hospital, vice-chairman; Olga Thiessen, University of Alberta Hospital, secretary-treasurer; and Paula Hopkins, Calgary Foothills Hospital, membership chairman.

Trends Reversing In Nursing Education

Ottawa. — 1968 was a year for changes in nursing education programs in Canada. "For the first time no students entered non-integrated basic baccalaureate degree programs," said Lois Graham-Cumming, director of research and advisory services for the Canadian Nurses' Association.

Baccalaureate degree programs that prepare students to qualify as registered nurses may be either integrated or non-integrated. In 1963, 221 students entered integrated programs that are organized and controlled in the same way as other units in the university; and 269 entered non-integrated programs, part of which are conducted outside the control of the degree-granting institutions. In 1965 the trend reversed — 340 students entered integrated, and 226, non-integrated programs. All admissions were to the integrated basic degree programs in 1968.

The officers and executive committee of CNA in 1965 endorsed the concept of an integrated degree program in response to recommendation 131 of the Royal Commission on Health Services (Hall Report).

Two types of postbasic baccalaureate programs in nursing are available to nurses who are graduates of diploma schools of nursing. One offers a major in a clinical area such as psychiatry, or a functional area such as administration; the other (general) type does not include a specialization within the nursing program. Five students graduated from the general postbasic program in 1963, and 178 graduated in 1968. Although the numbers have increased in the general program, three-quarters of all postbasic degree graduates in 1968 had a major.

From 1963 to 1967, more students completed a one-year diploma/certificate program than graduated with a postbasic baccalaureate degree. In 1968, however, the trend reversed and 60 percent of the students graduated with degrees.

(Continued on page 14)

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news

Ontario Supreme Court To Settle Terms Of Nurses' Contract

Toronto, Ont. – For the first time, the Registered Nurses' Association of Ontario and a nurses' association have taken a contract issue to court.

The *RNAO Newsette* reports that on December 17, 1968, an arbitration board made an award to settle contract terms between the Nurses' Association of St. Joseph's General Hospital, Peterborough, and their employer, retroactive to January 1, 1968.

On January 23, 1969, the arbitration board interpreted its own earlier decision as applying only to nurses who were employed at the hospital at the time the agreement took effect. Assisted by RNAO's employment relations department and legal counsel, the nurses' association appeared before Ontario Supreme Court Judge J.H. Osler, claiming that the arbitration board had exceeded its jurisdiction in issuing a second order purporting to interpret its own previous award.

Pay retroactive to January 1, 1968 ought to apply to all nurses who worked on the hospital staff during 1968, the report continued. The amount involved is about $6,000 for 17 nurses who left the hospital staff during the year. *N.B.: Word received at press time that Court ruled in favor of nurses and awarded costs to the nurses' association.*

College of Nurses To Close Waiver Clause

Toronto, Ont. – For the past two years, state registered general nurses from the United Kingdom and Eire, have been allowed to write the Ontario registration examination in pediatric and/or obstetric nursing without preparation in the particular area of nursing. Effective September 30, 1969, this practice will cease.

The director of the College of Nurses of Ontario, Joan C. Macdonald, explained this change in policy to *The Canadian Nurse.*

A waiver policy was established for a two-year period, which allowed nurses from the United Kingdom and Eire, who had not had courses in pediatric or obstetric nursing to write the registration examinations in these subjects. If they passed these examinations, they were registered in Ontario. Although this policy made supplemental courses no longer mandatory for admission to the two examinations, it did not negate the provision of courses for those who wished to take courses before writing the examinations.

The special conditions were set up to give an opportunity for registration to a

group of nurses who had come to Ontario and who were employed as graduate non-registered nurses.

The decision of the Council of the College is to close the waiver and to apply the policy which was applicable prior to the waiver. That policy was to require supplemental courses in obstetric and/or pediatric nursing to make up for deficiencies in the applicant's preparation to meet regulations in Ontario legislation.

Nurses from the United Kingdom and Eire who apply for registration without preparation in obstetric and/or pediatric nursing will be advised by the College of the kind and amount of supplemental preparation required. Miss Macdonald said that it would be advisable for these nurses to determine their eligibility before coming to Ontario. "If short-term preparation in either or both of these areas of nursing is available to them at home, it would be wise to obtain this preparation in advance," she said.

Miss Macdonald said that all nurses in Ontario will be required to meet the same requirements for registration and be subject to College discipline.

Alberta Nurses Accept New Contract

Edmonton, Alta. — A conciliation board award in the dispute between the Alberta Association of Registered Nurses and the Alberta Hospital Association on behalf of 2,500 nurses working in 28 hospitals in the province was accepted in May. *The AARN Newsletter* also reported the new contract provides a 20.9 percent increase in salary over two years. Retroactive to January 1, 1969, registered nurses in the province received $440 per month. Effective September 1, 1969 salaries increased to $465 per month. On May 1, 1970 nurses will receive $490 per month.

The agreement also provides an educational allowance of $25 per month for a university diploma, $60 for a baccalaureate, and $100 for a master's degree. After four years continuous service, nurses will have 20 working days vacation.

Summer Workshop For Nurse-Teachers

Charlottetown, P.E.I. — Thirty-two teachers from three hospital schools of nursing attended a three-day workshop here, August 6-8. Shirley R. Good, consultant in higher education, the Canadian Nurses' Association, conducted the sessions at the request of the Association of Nurses of Prince Edward Island.

Workshops were planned to assist the teachers as they prepared to change from a three-year to a "two plus one" curriculum. The three existing hospital schools are phasing out, and will be replaced

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"Effective teaching requires a thorough knowledge of content," Dr. Good said. "Then you need a plan to direct the level of knowledge, skills, and attitudes you hope the students will achieve," she continued. Dr. Good demonstrated several teaching methods during discussions on the development of philosophy, objectives, learning theories, criteria for effective teaching, and content guidelines. She suggested the teachers try various teaching methods, but cautioned that there must be content to make any teaching method exciting.

During the workshops, the teachers worked in small interest groups and developed a plan for philosophy, objectives, and learning experiences.

Summer Camp Holiday For Douglas Hospital Patients

Verdun, P.Q. – Fifty long-term patients from the Douglas Hospital left August 6 for a summer camp in the Laurentians. They were accompanied by 11 staff members. Another 100 patients went later as part of a rehabilitation program to help them learn how to use leisure time.

Dr. Henry B. Durost, executive director at the hospital, said the unusual project recognized that inability to use leisure time constructively is a source of emotional stress. Last year a few long-term patients were sent to camp as an experiment, and they responded so well to the change that the hospital now hopes to have a permanent camping program.

David Taube, recreational therapist and director of the camp, said boating, hiking, swimming, and overnight trips with campfire cooking were among the activities arranged for the patients.

A day camp on the hospital grounds is provided for young patients of the children's services. Some children are sent away to regular camps each year by community organizations.

"Canadian Hospital" Attacks New Postal Rates

Toronto, Ont. – "*Canadian Hospital* like many sister publications in the health field and other professional journals, is being forced to subsidize commercial profit-making publishing firms through an arbitrary ruling by the Post Office Department," says an editorial in the June issue of *Canadian Hospital,* the publication of the Canadian Hospital Association.

The editorial, signed by Dr. B.L.P. Brosseau, executive director of the CHA, accuses the department of favoring publications of commercial firms over publications of organizations "responsible to the profession they represent."

The editorial was protesting the increased postal rates that have affected most organizational journals in Canada, while leaving profit-making publications at lower postal rates. The Canadian Nurses' Association has faced an increase from $750 per month to $11,000 per month for *The Canadian Nurse* and *L'Infirmière canadienne.*

"Prior to rulings by the Post Office Department," the editorial continued, "we understand that the giant publication monopolies of MacLean-Hunter and Southam Business Publications approached many of the successful organization publications in an effort to take over these magazines."

The editorial also argued that the CHA was not an organization "in the truest sense," because it did not represent a single profession but "a total of 18 organizations." Therefore, it continued, it would not fall under the definition used to make the ruling forcing it to pay increased rates.

"We have no quarrel with increased postal rates because we do not expect to be subsidized at the expense of the public. But we want the government to play fair ball," it concluded. □



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names



Frances M. Howard (R.N., Saint John General Hospital, Saint John, N.B.; post-graduate course in obstetrics, Boston Lying-In Hospital, Boston, Mass.; certificate in nursing education, U. of Toronto; B.N., School for Graduate Nurses, McGill U.) left the staff of the Canadian Nurses' Association in August. She will continue studies toward a master's degree in nursing service administration at the University of Western Ontario in London.

As CNA consultant in nursing service since 1963, Miss Howard traveled across the country to direct regional workshops in problem solving for hospital directors of nursing service, and acted as CNA consultant to the association's standing committee on nursing service and the ad hoc committee on standards for nursing service.

Before she joined CNA staff in 1958, Miss Howard had worked as obstetrical supervisor and instructor at the General Hospital in Port Arthur, Ontario; nursing arts instructor at the Oshawa General Hospital, Oshawa, Ontario; assistant supervisor of the delivery room at Boston Lying-In Hospital; and had done general duty nursing at the Saint John General Hospital, Saint John, New Brunswick.

Miss Howard was recently awarded the St. John Ambulance $1,000 Margaret MacLaren bursary for graduate study. She has also received a $1,000 bursary from the Ontario Red Cross Society, and a Canadian Nurses' Foundation fellowship for her master's studies.



Helen T. Stevenson (R.N., School of Nursing, Johns Hopkins Hospital, Baltimore, Md.; B.Sc.N., U. of Utah, Salt Lake City, Utah; M.N., U. of Washington, Seattle, Wash.) has been appointed director of the School of Diploma Nursing, Saskatchewan Institute of Applied Arts and Sciences, Saskatoon.

Mrs. Stevenson has held a variety of positions in nursing service and nursing education. She was teacher and coordinator of a diploma nursing program at Holy Cross Hospital, Salt Lake City, Utah, and was an instructor and assistant professor at the College of Nursing, Brigham Young University, Provo, Utah. She has also worked as a public health nursing supervisor with the Seattle-King County Health Department, Washington.

There was much excitement among the staff of *The Canadian Nurse* when the news was received from Carleton University in Ottawa that **Glennis N. Zilm,** former assistant editor of this journal, had been awarded the university medal in journalism. This means she has the highest standing of all the students graduating in journalism this year.

Miss Zilm left *The Canadian Nurse* in January to complete her final year at Carleton. She had been assistant editor since October 1964.

Her colleagues at the Canadian Nurses' Association had the opportunity of working with her again in June, when she rejoined the staff temporarily as part of CNA's public relations team at the ICN Congress. Shortly afterward she left for Edmonton, Alberta, and a position with The Canadian Press.



Lucille C. Peszat (Reg.N., St. Joseph's School of Nursing, Chatham, Ont.; B.Sc.N., U. Western Ontario; M.Ed., Ont. Institute for Studies in Education, U. of Toronto) has been appointed coordinator of formal continuing education programs, Registered Nurses' Association of Ontario.

Miss Peszat was formerly a curriculum consultant with the Quo Vadis School of Nursing in Toronto. She has held positions as lecturer at the University of Ottawa; nursing adviser in the External Aid Department to the government of Trinidad and Tobago; hospital careers consultant for the Ontario Hospital Association; and instructor at St. Joseph's Hospital School of Nursing, Chatham, Ont.

Margaret E. Harper (Reg.N., Guelph General H.; clinical supervision, U. of Toronto) has been appointed assistant director of nursing, Peel Memorial Hospital, Brampton, Ont.

Miss Harper was formerly director of inservice education at the same hospital.



Nicole Dion (R.N., Oldchurch H., Romford, Essex, England; dipl. nurs. admin., U. of Montreal) has been appointed executive coordinator, United Nurses of Montreal.

Miss Dion has held the positions of staff nurse, head nurse, and nursing supervisor at The Montreal General Hospital.



The nursing consultant in highereducation for the Canadian Nurses' Association leaves CNA House in August for Calgary. **Shirley R. Good,** (Reg.N., Women's College Hospital, Toronto; Certificate, Clinical Supervision, Medical-Surgical Nursing, U. of Toronto; B.S.N., M.Ed., Drury College, Springfield, Mo.; Ed.D., Teachers College, Columbia U.) has been appointed the first director of the school of nursing at the University of Calgary.

In her position at CNA for the past two years, Dr. Good visited universities across the country, providing consultation services for the establishment of new schools of nursing and the improvement of existing baccalaureate and master's programs. She also advised individuals on matters of university education for nurses in Canada.

Dr. Good has conducted numerous nursing studies, submitted briefs to the government, and has written articles for Canadian and International journals.

In 1964 and 1965 she was awarded the Canadian Nurses' Foundation fellowship for doctoral study.

Dr. Good has held varied nursing positions at New Mount Sinai Hospital, Toronto; Lady Dunn Hospital, Wawa, Ontario; Women's College Hospital, Toronto; School of Nursing, Toledo Hospital, Toledo, Ohio; Springfield Baptist Hospital, Springfield, Mo.; and the school of nursing, University of Western Ontario, where she was an assistant professor, lecturing in nursing service administration.

As director of the University of Calgary's school of nursing, Dr. Good plans to "educate practitioners of nursing who

names

(Continued from page 17)

will give leadership in the delivery of patient care." She is strongly opposed to including administration or teaching majors at the baccalaureate level and would like to see a bachelor of *nursing* degree conferred.

The first students will enter the school in September 1970. Initially, the program will be designed for high school graduates, with plans for post-basic baccalaureate education in September 1972.



After 34 years of service to the Toronto department of public health, **Eileen Cryderman** (Reg.N., Toronto Gen. H., Cert. in public health nursing, U. of Toronto; B.Sc., Columbia U.) retired as director of the division of public health nursing.

Miss Cryderman left the Toronto General Hospital soon after graduation to go to Kirkland Lake, nursing at the Ontario Red Cross Outpost Hospital. She then joined the Toronto department of public health as a staff nurse, later becoming a district supervisor. After returning to University, she joined the East York-Leaside Health Unit, guiding the unit until 1952. When she returned to the Toronto department of public health as assistant director of public health nursing. She became director in 1954, remaining in the position until her retirement during the summer.



Replacing Miss Cryderman as director of the division of public health nursing for the Toronto department of health is **Myrna Slater** (B.Sc.N., U. of Toronto; M.Sc.N., U. of Minnesota).

Miss Slater, a primary school teacher before entering nursing, joined the Toronto department of health in 1951 as a staff nurse, later becoming assistant supervisor, educational consultant, and assistant director. She is currently president of the Ontario Public Health Association.

Kathleen M. Clark (B.Sc.N., U. of Toronto) has been appointed an instructor, University of British Columbia School of Nursing.

Mrs. Clark was formerly an instructor at the Clarke Institute of Psychiatry, Toronto. She was awarded the Ontario Mental Health Association Scholarship for the fourth year of the baccalaureate program.



Virginia D. Lévesque B.Sc.N., U. of Santo Tomas, Manila, Philipines; M.Sc.(A), McGill U.) has been appointed director of nursing at Oromocto Public Hospital, Oromocto, New Brunswick.

Mrs. Lévesque has worked as a supervisor at Victoria Public Hospital in Fredericton, N.B., a head nurse at the Jewish General Hospital in Montreal, and a staff nurse at Hamilton General Hospital.

Before coming to Canada, Mrs. Lévesque worked for two years as part of an exchange program in the intensive care unit for open heart surgery at St. Mary's Hospital, Rochester, Minnesota.

The Saskatchewan Registered Nurses' Association has announced the retirement of **Grace Motta** (R.N. Winnipeg Gen. H.; dipl. in teaching and supervision, U. of Toronto) after 13 years as registrar of SRNA.

Miss Motta's experience includes general and private duty nursing in Winnipeg, a year as clinical instructor at the Winnipeg General Hospital, and 13 years as superintendent of nurses and director of nursing at Moose Jaw Union Hospital, Moose Jaw, Saskatchewan. She joined SRNA as registrar in 1956, having served as president from 1952 to 55. She was acting executive secretary-treasurer twice: 1957-58, and 1966-67.

Replacing Miss Motta as registrar of SRNA is **Edna Dumas** (R.N., Moose Jaw Union H., Moose Jaw, Sask.; dipl. in teaching and supervision, and B.Sc.N., U. of Sask.). After nine years away from nursing to raise her four children, Mrs. Dumas joined the staff of the Saskatoon Sanatorium. She moved to the Saskatoon Geriatric Center for two years, then became director of nursing education at Saskatoon City Hospital. Two years later she became associate director of nursing service at the same hospital, then deputy director of nursing service.

Sheila McIver, (R.N., Grey Nuns' Hospital, Regina) was awarded the Good Citizenship award in Victoria, B.C., for her work in geriatrics. The award was given by the Native Sons of British Columbia. Mrs. McIver described part of her work in the April, 1969 issue of *The Canadian Nurse.*

The University of Ottawa has announced the appointment of three nurses to the position of lecturer.



Basanti Bhaduri (B.Sc.Nsg., College of Nursing, New Delhi, India; M.N., U. of Delhi; dipl. in coronary care, Overlook Hosp., Summit, New Jersey) joined the University July 14. Miss Bhaduri has worked as head nurse and sister tutor in India. From 1966 until last year she worked as staff nurse, team leader, and assistant to an instructor at Overlook Hospital in Summit, New Jersey. For the past year she has taught nursing at the Ottawa General Hospital.



Marjorie Carroll (R.N., Ottawa Civic Hospital; B.Sc.N. Ed., U. of Ottawa) worked at the Provincial Hospital in Campbellton, N.B., as head nurse and psychiatric instructor for five years, then spent two years as nursing tutor in Emekuru, Nigeria. From 1967 to 1969 she was a clinical instructor at the Royal Victoria Hospital in Montreal.



Purification Barron (R.N., Hôpital St-Luc, Philippines; dipl. in pediatric nursing, Mount Sinai Hosp., New York; B.Sc.N., Columbia U., New York; M.N., Philippines Women's University) had 15 years of experience as a staff nurse and instructor in the Philippines before coming to North America in 1965. Mrs. Barron spent two years as an instructor at Lorrain School of Nursing in Pembroke, Ontario, and another year at the Ottawa General Hospital.



Dorothy Kamp (R.N., St. Paul's Hosp., Saskatoon; dipl. in nsg. admin., B.Sc.N., U. of Windsor) joined the Metropolitan General Hospital in Windsor, Ont., as director of nursing service in May.

Mrs. Kamp's nursing experiences include five years as operating room supervisor at the Union Hospital in Melfort, Saskatchewan, and 11 years as general duty and instructor for inservice education at Metropolitan Hospital, Windsor. □



Does Jane Cowell know the facts about dandruff?

Probably not!

The facts are dandruff is a medical problem and requires medical treatment. Ordinary shampoos cannot control dandruff.

New formula Selsun can!

The doctors you know are undoubtedly familiar with Selsun. And they prescribe it because it's medically recommended. And proven effective in 9 out of 10 severe dandruff cases.

Our new formula Selsun is as effective as the old. We use the same efficient anti-seborrheic — selenium sulfide. We've simply improved the carrier. A more active detergent produces foamier lather — a finer suspension gives smoother consistency.



To top off new formula Selsun we added a fresh clean fragrance and put it in an attractive unbreakable white plastic bottle.

If you know someone with a dandruff problem tell them to ask their doctor about Selsun. And if dandruff worries you — ask your own doctor.

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NO. 66
POSEY SAFETY BELT
(Patent Pending)



This new Posey Belt provides safety to a bed patient yet permits him to turn from side to side. Also allows sitting up. Made of strong, reinforced white cotton webbing; with flannel-lined canvas reinforced insert. Strap passes under bed after a turn around spring rail to anchor. Friction-type buckles. Buckle is under side of bed out of patient's sight and reach. Also available in Key-Lock model which attaches to each side of bed. Small, medium and large sizes. No. 66. $8.25. Key-Lock Belt, No. K66, $13.95. No. 66-T. (ties on sides of bed) $8.10.



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(Patented)

Allows maximum freedom with safe restraint. An improvement over sideboards, the Posey belt is designed to be under the patient and out of the way. Belt and bed strap are of heavy white cotton webbing; loop and pad of cotton flannel. Friction-type, rust-resistant buckles. Small, Medium and Large sizes. Safety Belt, No. S-141, $6.90. (Extra heavy construction with key-lock buckles, No. 453, $19.80)

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dates

September 18-20, 1969
Annual conference on obstetrics, gynecologic, and neonatal nursing, Sheraton-Brock Hotel, Niagara Falls, Ontario. Sponsored by District V of the American College of Obstetricians and Gynecologists.

September 22-24, 1969
Annual Convention, Alberta Medical Association, Calgary, Alberta.

September 23-25, 1969
10th annual meeting and convention of Associated Nursing Homes, Inc., Sheraton-Connaught Hotel, Hamilton, Ont.

September 24-27, 1969
Canadian Association for the Mentally Retarded, National Planning Symposium, Hotel London, London, Ont. For information write: CAMR, 149 Alcorn Ave., Toronto, Ont.

September 28 - October 3, 1969
13th annual Registered Nurses' Association of Ontario Conference on Personal Growth and Group Achievement, Delawana Inn, Honey Harbour, Ont.

October 6-8, 1969
Annual nurses' convention, sponsored by the American College of Obstetricians and Gynecologists, Marlborough Hotel, Winnipeg. For further information write to: Mrs. Jordan, c/o Women's Pavilion, Winnipeg General Hospital, 700 William Avenue, Winnipeg 3, Man.

October 6-31, 1969
Advanced program in Health Services Organization and Administration, University of Toronto School of Hygiene. This is the first of two parts of the course. Fee: $200 for each part. Write to: Dr. R.D. Barron, Secretary, School of Hygiene, University of Toronto, Toronto 5, Ont.

October 7-9, 1969
Operating Room nurses of Nova Scotia study group, fall convention, Halifax Infirmary Hospital, Halifax

October 9-10, 1969
Annual Convention, Catholic Hospital Conference of Alberta, Edmonton, Alberta.

October 9-10, 1969
Ontario Hospital Association, 45th annual convention, Royal York Hotel, Toronto.

October 10, 1969
Homecoming 69, for all graduates of any nursing programs at the University of Ottawa. For information contact: Miss M. Olsiak, pro tem chairman, School of Nursing, University of Ottawa, 30 Stewart St., Ottawa, Ont.

October 16-17, 1969
Continuing Nursing Education Course in Nursing the Adult with Long Term Illness. The University of British Columbia, School of Nursing, Vancouver, B.C.

October 24, 1969
Catholic Hospital Conference of Ontario Nursing Committee meeting, Westbury Hotel, Toronto.

October 25-26, 1969
Catholic Hospital Conference of Ontario, annual convention, Westbury Hotel, Toronto, Ontario.

October 25, 1969
Fraser Valley District Registered Nurses' Association of British Columbia Education Day, Chilliwack, B.C., Evergreen Hall Auditorium. Fee: $5.00. Write: Mrs. Mary McCallum, 127 Princess Ave. E., Chilliwack, B.C.

October 30-31, 1969
Continuing Nursing Education Course in Pediatric Nursing. The University of British Columbia, School of Nursing, Vancouver B.C.

November 10-14, 1969
American Public Health Association meeting, Philadelphia, Pa. For information write: American Public Health Association, 1740 Broadway, New York, N.Y.

November 11-13, 1969
Quebec Operating Room Nurses' Group, annual convention, Skyline Hotel, Montreal.

November 13-14, 1969
Continuing Nursing Education Course in Nursing the Adult with Acute Illness. The University of British Columbia, School of Nursing, Vancouver, B.C.

November 19, 1969
Symposium of Operating Room Study Group of Manitoba in conjunction with the Manitoba Health Conference. Fort Garry Hotel, Winnipeg, Man. Contact: Mrs. Diane Aboud, Corresponding Secretary, St. Boniface General Hospital, St. Boniface, Manitoba. □

Vanquin
(pyrvinium pamoate)

• Convenient, economical single-dose oxyuricide • Single-dose elimination of pinworm infection in 90-100% of cases • Notable freedom from serious and other side effects • Especially valuable for institutional and family use • Available as a pleasant-tasting suspension or as sugar-coated tablets • **Dosage:** Children and adults, a single oral dose equivalent to 5 mg. per Kg. body weight. This is approximately equivalent to one 5-cc. teaspoonful of Vanquin Suspension or one Vanquin Tablet for each 22 pounds of body weight. **Precautions:** Tablets should be swallowed whole to avoid staining teeth. Pyrvinium pamoate will stain most materials. Stools may be coloured red. **Side Effects:** Infrequent nausea and vomiting and intestinal complaints have been reported. **How Supplied:** Vanquin is available as a pleasant-tasting, strawberry-flavoured suspension in 1-oz. and 2-oz. bottles; and as sugar-coated tablets in packages of 12, and bottles of 25 and 100. Vanquin Suspension contains the pamoate equivalent of 10 mg. pyrvinium base per cc. Each Vanquin Tablet contains the pamoate equivalent of 50 mg. pyrvinium base. Detailed prescribing information available on request.

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BANISH PINWORM INFECTION WITH A SINGLE DOSE

Vanquin*
(pyrvinium pamoate)
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new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.



Quick-Switch Parallel Bars

A team of working physical therapists has designed new motorized parallel bars that can be adjusted in seconds. The fast adjustment to height and width for each patient is made possible by four switches and two push buttons in the activation and control mechanism.

The average adjustment per patient with the motorized parallel bars takes about eight seconds, compared with about three minutes for manually adjusted bars. This saving amounts to more than $1,000 a year for a single unit.

By adjusting height from 25 to 40 inches and width from 16 to 25 inches, this device can easily accommodate children or adults. Chromium plated steel handrails assure rigidity and long life; an optional tapered steel base allows easy access for wheelchairs.

For further information contact: Presentation of Canada Limited, 74 Victoria Street, Suite 616, Toronto 1, Ontario.

Erratum

The June issue of The Canadian Nurse gave an incorrect address for information concerning the Surgical Prep Blade. The manufacturer has informed us the correct address is: Mr. Gilles Michaud, ASR Medical Industries, 5555 Royalmount Avenue, Montreal, Quebec.

Underwater Chest Drainage

Sterile underwater chest drainage sets are available in one, two, or three bottle setups. A rack is provided with each bottle to prevent accidental tipping. Each bottle is calibrated to 1500 cc. and is labeled. The screw top eliminates glass rods, cork and tape; on the tubing to the patient are two clamps making a tight closure.

For further information write: Hospital Products Division, Chesebrough-Pond's (Canada) Ltd., 150 Bullock Drive, Markham, Ontario.

Automatic Infusion Pump

An automatic infusion pump requiring a simple "dialing in" for the desired infusion rate in ccs per hour has been developed by the IVAC Corporation.

The pump needs no reference to charts in setting up; instrument never requires calibration, nor readjusting during infusion. It will accept any size intravenous tubing, and the rate desired is independent of tube inside diameter.

The instrument will shut itself off when the last drop leaves the bottle and signal the nurse at her station, thus eliminating air infusion.

For further information contact: Standard Hospital Supply, 2276 Dixie Rd., Cooksville, Ontario.



Disposable Electrodes

These disposable electrodes are to be used with electronic monitoring equipment in hospitals. They are lightweight, with sturdy, one-piece construction eliminating the need for heavy ECG cables and metal plate or needle electrodes.

Each disposable electrode has a 36-inch lead and a positive adhesion to provide maximum patient-electrode contact. They are designed for long-term monitoring without discomfort to the



patient. Their flexible construction and application are designed to avoid skin irritation, as well as the time-consuming need to relocate continually electrodes from one portion of the body to another. They are available in dispenser packages containing 50 individually wrapped electrodes connected in a roll.

For further information contact: Baxter Laboratories of Canada, 6405 Northam Drive, Malton, Ontario.

Tinactin Cream

Tinactin (tolnaftate), a fungicide for treatment of fungus infection of the skin, including athlete's foot, is now available in a new cream form.

Available in 15 Gm. tubes, this cream kills tinea organisms with speed and convenience, while showing virtually no side effects. Non-sensitizing, non-irritating, and not active systemically, Tinactin is odorless and non-staining.

This product is also available as a solution in 15cc. bottles or as a powder in 40 Gm. tubes.

For further information, write to: Schering Corporation Limited, Pointe Claire, Quebec.



Ethylene Oxide Sterilizers

Automatic, portable ethylene oxide sterilizers are designed for the sterilization of virtually any article used in hospitals.

Using disposable "Steri-Gas" cartridges, the units feature simple, automatic unattended operation for sterilizing surgical, diagnostic and optical instruments, plastic and rubber materials, patients' personal effects, and other items sensitive to the effects of heat and moisture.

All units have anodized aluminum chambers and a case finish of silver-gray hammertone enamel.

For further information, write to: 3M Company, P.O. Box 5757, London, Ont.

Magnetic Tape Recorder

The Dallons Automatic Memory Tape Loop Recorder is designed for use in coronary and intensive care units. The unit features two separate recording channels, one for EKG signals and the other for voice information, permitting a descriptive or analytical voice track to be recorded either simultaneously with the EKG pattern, or at a later time.

The equipment is designed to record a patient's EKG information continuously, erasing older information and recording new information on the same tape. The unit automatically shuts off at a preset length of time after onset of an alarm condition. This provides several minutes of data showing the heart action preceding, during, and immediately following the emergency. Tapes in easily loaded cartridges are available in lengths from 70 seconds to 10 minutes.

A built-in speaker and a microphone for recording on the voice track are provided with the unit. A safety interlock switch prevents inadvertent loss of previously recorded information. Either 115 volt, 60 cycle; or 220 volt, 50 cycle units can be provided, permitting the recorder to be operated from standard hospital wall outlets.

For further information contact: Bionetics Ltd., 6420 Victoria Avenue, Montreal 26, Quebec.

A Chemical Disinfection Unit

Market Forge has developed a chematic control chemical disinfection unit that provides control over the chemical disinfection process.

The chematic control is designed for use in the hospital's central sterile service, the operating room cystoscopy, anesthesia, and inhalation therapy areas. In addition to providing all facilities to observe proper technique, chematic control automatically assures that all items are exposed for the correct amount of time. Chematic control is available as a complete unit that can be placed on an existing counter or cart or as a self-contained chemical disinfection work station. Features include dial timers; interlocked covers; transfer baskets; indicator lights; covers, trays, and transfer baskets removable for autoclaving; tray syphon; soak and rinse trays; and transfer baskets of inert material to be used with all generally used chemical disinfectants without chemical reaction; and stainless steel construction for durability and cleanliness.

For further information contact: Gordon G. Brown & Co., Ltd., Suite 23, 1875 Leslie Street, Don Mills, Ontario.

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$18

Perspiration is no longer one of a shoe's worst enemies. Now Air Step brings you a shoe made of genuine Servotan* leather, specially treated to resist drying, cracking and discoloration due to perspiration. The shoes stay unbelievably soft. So easy to clean, too, with soap and water.

And Air Step has the famous Wondersole. (See illustration below.)



*Wondersole fits your sole, dip for dip, rise for rise.



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$18
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For nursing convenience...

patient ease

TUCKS

offer an aid to healing, an aid to comfort

Soothing, cooling TUCKS provide greater patient comfort, greater nursing convenience. TUCKS mean no fuss, no mess, no preparation, no trundling the surgical cart. Ready-prepared TUCKS can be kept by the patient's bedside for immediate application whenever their soothing, healing properties are indicated. TUCKS allay the itch and pain of post-operative lesions, post-partum hemorrhoids, episiotomies, and many dermatological conditions. TUCKS save time. Promote healing. Offer soothing, cooling relief in both pre-and post-operative conditions. TUCKS are soft flannel pads soaked in witch hazel (50%) and glycerine (10%).

TUCKS — the valuable nursing aid, the valuable patient comforter.



Specify the FULLER SHIELD® as a protective postsurgical dressing. Holds anal, perianal or pilonidal dressings comfortably in place without tape, prevents soiling of linen or clothing. Ideal for hospital or ambulatory patients.

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new products

Garamycin Ophthalmic

Garamycin ophthalmic is effective against most common pathogens, including penicillin-resistant staphylococcus, pseudomonas and proteus. It is recommended for the treatment of superficial bacterial infections of the eye and for the prevention of infection resulting from injury to the eye or adjacent areas.

Garamycin ophthalmic is available in 0.3 percent solution or ointment. Each cc. of solution or gram of ointment contains 5 mg. of gentamicin sulphate, equivalent to 3 mg. of gentamicin base.

The solution is a stable (2 years), sterile form, ready for immediate use. The ointment form, in a 1/8 oz. tube with applicator tip, is suggested where lubrication or sustained medication is desirable.

For further information contact: Corporation Ltd., Pointe Claire, Quebec.



Blood Analyzer

The Blood Analyzer II is designed to permit the physician's own office staff to perform a variety of blood chemistries or for a group practice or clinical laboratory already engaged in volume blood-testing.

A direct-reading, photoelectric colorimeter, the new blood analyzer offers savings in the time and the cost of blood testing. Average elapsed time per test is less than 15 minutes, with a total average operator time of two minutes. Average cost per test can be as low as 19 cents using bulk reagents.

Ten different blood chemistries are presently available: albumin, alkaline phosphatase, bilirubin, B.U.N., cholesterol, cyanmethemoglobin, oxymethemoglobin, total protein, true glucose, and uric acid. New chemistries are in the final prerelease test stage and others are being developed to be added to the blood analyzer's operation.

For additional information write: Mr. H. Court, 879 Warwick Drive, Burlington, Ontario. □

Fleet ends ordeal by Enema® for you and your patient



Now in 3 disposable forms:

- **Adult** (green protective cap)
- **Pediatric** (blue protective cap)
- **Mineral Oil** (orange protective cap)

Fleet — the 40-second Enema* — is pre-lubricated, pre-mixed, pre-measured, individually-packed, ready-to-use, and disposable. Ordeal by enema-can is over!

Quick, clean, modern, FLEET ENEMA will save you an average of 27 minutes per patient — and a world of trouble.

WARNING: Not to be used when nausea, vomiting or abdominal pain is present. Frequent or prolonged use may result in dependence.
CAUTION: DO NOT ADMINISTER TO CHILDREN UNDER TWO YEARS OF AGE EXCEPT ON THE ADVICE OF A PHYSICIAN.

In dehydrated or debilitated patients, the volume must be carefully determined since the solution is hypertonic and may lead to further dehydration. Care should also be taken to ensure that the contents of the bowel are expelled after administration. Repeated administration at short intervals should be avoided.

Full information on request.

*Kehlmann, W. H.: Mod. Hosp. 84:104, 1955

FLEET ENEMA® — single-dose disposable unit

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in a capsule

Plugged in

Language difficulties at the ICN congress in June were minimized by the use of simultaneous translation facilities into the four official languages of the ICN. Unfortunately for two Spanish-speaking nurses, the translation facilities did not extend to outside activities leading to various interesting incidents.

The two nurses entered a Montreal restaurant one evening, still carrying the portable headphones that plugged into the translation service. After several moments of fruitless sign language, one of the nurses excitedly motioned to the waitress to don the headphone, and seized the plug to speak into.

Whether or not the nurses ever were served is still in doubt.

Nursing at its best

Recently, a nursing educator friend of ours returned from a year's postmaster's studies in California. During the time she was there she worked as a general duty graduate in a rehabilitation hospital "to keep a hand in patient care." That's a commendable sentiment from today's educators, we think.

One of the interesting stories she has to tell concerns the use of wine with the afternoon and evening meals, a custom rapidly growing in California's hospitals.

There were several patients of Italian origin on the ward, and one small glass of wine merely whetted the appetite. So the enterprising nurses made rounds of the ward and kept a list of all the teetotalers. Then as they passed out the trays, they whipped the glasses off those of the abstainers and onto those of the Italians. Everybody was happy.

Catnip confusion

Readers of *The Journal of the American Medical Association* enjoyed pointing out an error in the article "Catnip and the Alteration of Consciousness" (February 17, 1969).

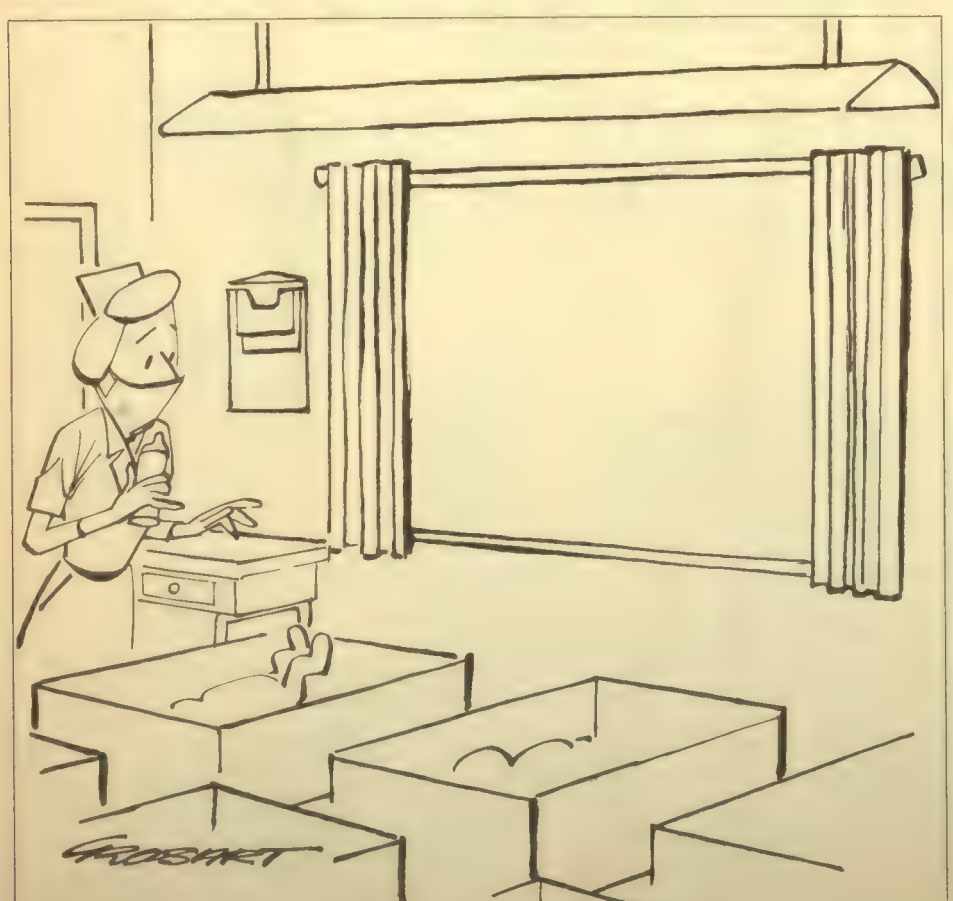
The error – the labeling of *Cannabis sativa* (marihuana) for *Nepeta cataria* (catnip) and vice versa – resulted in some of the following reader comments *(JAMA,* April 14):

"One of my hippied patients noted, with a pardonable snicker, that the labels for *Cannabis* and catnip had been interchanged. He confirmed the descriptions of the psychedelic effects, calling them 'low high.'"

"A short time ago an elderly gentleman in Grand Rapids, Michigan, was arrested for collecting marihuana. To their chagrin, the police discovered that he had a bag of catnip for his cat. Apparently the police had used the same botanist who labeled the illustrations in the article."

"One exposing his pet cat to what is termed *Cannabis* might get the false impression that he was sheltering a feline junkie."

"Being a bit of a catnip and mint chewer myself, it is shattering to learn I was denied the pleasures I might have had, had I known I was nibbling at the edge of psychedelia."



"Here's one for the road, you're going home today..."

Extendible shoes

A Canadian doctor has come up with an idea for a shoe that no manufacturer will touch according to a Canadian Press story from Edmonton. Harold England has invented a child's shoe which can be extended one size by a simple operation requiring only a screwdriver.

"It's a tremendous idea" said the inventor, "but I'm living in the wrong society. No manufacturer is going to take on a shoe that could replace the sale of two pairs of shoes."

Drink "hard," live longer

The London School of Hygiene and Tropical Medicine reports that drinking hard water seems to keep people alive longer. The school conducted a survey of 61 county boroughs in England and Wales where the population was 80,000 and over. The survey showed that the harder the water and the more calcium it contained, the lower the death rate – especially in cases of cardiovascular disease and bronchitis. It appears that perhaps calcium, magnesium, and sodium are responsible for keeping hard-water drinkers alive longer. If not, then hard water's trace metals such as boron, iodine, fluorine, and silica may be the reason. – *The Horner Newsletter,* June 1, 1968. □

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OPINION

Inservice for teachers, too?

No professional nurse can function well without continuing to learn. And nurse educators are no exception.

Shirley Post, B.Sc.N.Ed.

Any educational administrator who wants a high quality educational program is obliged to find, select, and retain the finest faculty possible. She looks for qualified, competent faculty and considers each individual teacher's academic qualifications, clinical experience, clinical depth, teaching ability, attitudes, philosophy, and character. As well, she must consider the teacher's potential for professional development.

Once the administrator has obtained well-qualified faculty members, she must accept a certain responsibility for helping to increase their effectiveness as teachers and as professional nurses, if the school is to maintain this "quality" aspect.

No professional nurse can function well or for long without continuing to learn. A nurse who graduated five years ago and has not studied in her field since is out of date. Nursing educators are not exceptions.

Schools of nursing can no longer tolerate the kind of teacher who has not changed her lecture content or method of presentation since she prepared her course 10 years ago. If administration fails to recognize and help this staff member, today's students will call attention to her.

Mrs. Post, a graduate of the Toronto Western Hospital and the University of Ottawa, is Assistant Director, School of Nursing, Ottawa General Hospital.

Each teacher must continue to learn. If she stops learning, she slips behind; new knowledge and technology does not wait for the laggard, but passes by.

Nursing educators are, in a sense, nursing leaders. They cannot know everything, but must be aware of trends, of changes, of where to look for knowledge. They must keep pace with the times if they are to motivate, stimulate, and guide student nurses of today and tomorrow.

Blueprint needed

The director of a school of nursing can help faculty members to grow. She must believe in the philosphy of continuing education. She must provide incentives and stimulation to encourage improvement of faculty competence. As director, she must provide leadership in planning programs with her staff, or delegate this function to a member of her faculty. She must consider inservice needs when planning her budget. In short, she must remember that the faculty of a school of nursing needs a planned inservice program too.

An inservice program does not just happen. To make any program a reality, we must have a blueprint. We must know *what* we want to do, *why* we want to do it, and *how* we will achieve it. This means a written philosophy and objectives.

The objectives may be very flexible; they may even change from year to year. However, they should be comprehensive

and include personal, emotional, and social aspects as well as professional concerns of the faculty.

There are nine considerations for a faculty inservice program:

- It must be carefully planned.
- It must be flexible enough to take advantage of unforeseen educational opportunities.
- It must be comprehensive
- It must meet the needs of the faculty members.
- It must meet the needs of the institution.
- It must be supported by administration.
- It must be supported by faculty.
- All faculty must actively participate.
- A budget must be established.

Four areas of concern

Inservice programs for faculty should cover four areas: orientation; group education; individual growth opportunities; and counseling.

Orientation is planned by the school administration. It introduces the new faculty member to the school and to the hospital and staff. It gives her written philosophy, objectives, and organizational patterns. Personnel policies, faculty by-laws, committee structures, and job descriptions are discussed.

The new teacher needs an overview of the total curriculum, as well as an introduction to her own area. Student evaluations, student guides, and other forms must be understood.

At the Ottawa General Hospital School of Nursing, orientation is planned for new teachers by the assistant directors and the medical-surgical coordinator. One week is spent at the school with a planned program, one week in the clinical area with an instructor, and one week with nursing service orientation program. Each teacher receives a loose-leaf manual containing all policies and a sample of all records used. A loose-leaf binder is used to make additions of material simple; it also serves as a file for the minutes of future faculty meetings.

Group education permits every faculty member to continue to learn, to improve her teaching effectiveness, to keep up with current trends, and to broaden her horizons. At our hospital we try to create an atmosphere whereby each faculty member wants to continue to learn. To provide stimulation, the administration has planned group programs twice monthly, on Wednesday afternoons, from 1:30 to 3:30 p.m.

When planning first began, faculty members were asked about their interests and needs. Following this discussion, the assistant director, whose function is to act as inservice coordinator, listed a number of possibilities. Priorities were set at the following faculty meeting, and arrangements left with the assistant director.

Individual growth opportunities need to be provided for an inservice program. A keen, participating faculty member, with an evident interest in continuing education opportunities, provides an excellent role model for students. Planning for these opportunities is the responsibility of the faculty member, but administration can offer encouragement and often financial assistance. Two members of our faculty are on the executive of the Ottawa East Chapter of the Registered Nurses' Association of Ontario. We have had members of the faculty at seminars, workshops, and conventions in Detroit, Toronto, Kingston, Ottawa, and Montreal this year — 20 different functions in all. Four faculty members went to the provincial annual meeting in May and five attended the International Council of Nurses Congress in June.

In her article in the February '69 issue of *Nursing Outlook*, Eleanor Muhs includes counseling as part of an inservice education program. This is a good idea. Every director of a school of nursing needs to spend time listening to her staff, encouraging them to try new methods, discussing plans for going on with their own education, and supporting them in efforts to provide quality nursing education for their students.

A beginning — not an end

Faculty improvement is a term that is neither clear nor explicit. At our hospital, the inservice program for teachers has created a happy, friendly atmosphere, has helped keep our teachers motivated and interested. They participate. They try new methods. They ask to go to conferences, and are even willing to spend their own money to go because they believe it is important and they will learn. They share their experiences with colleagues.

This is only the beginning of course. What of the future for inservice in schools of nursing?

I believe that in the future we shall see more programs planned between service and education. We shall also see sharing of programs between schools of nursing, especially in terms of human and financial resources. Planning together cuts costs and provides everyone with better programs.

I also foresee continuing education programs being planned, not only within the confines of one or two schools, but locally and regionally. Perhaps university schools of nursing will provide leadership by offering continuing educational opportunities for graduates in the community through evening courses or workshops. Other community resources also could be utilized for educational programs.

I see broader content areas with programs including nurses, doctors, administrators, and other health care workers.

I believe the day is not far off when nursing schools will offer sabbatical leaves, perhaps a year, or even a term, so faculty members have an opportunity to keep pace with the times. □

Nursing associations — are they coming or going?

If a professional organization fails to grow and change as times dictate, it will decline and gradually fade out of a useful role. In which direction are the professional nursing associations going?

Glennis Zilm, B.Sc.N., B.J.



They're coming, according to Laura Barr, executive director of RNAO.

Every association, if it is to survive and be successful, must periodically reexamine its goals, structure, functions, and ways of carrying out its duties. It must be prepared to change if that examination reveals that it is not meeting the needs of its members and the needs of the society.

During the present biennium, the Canadian Nurses' Association has appointed a special committee to examine its goals and functions. During the past five years, six of the provincial nursing associations have undertaken a comprehensive review of their roles, goals, structure, and functions. Two more are planning such studies.

Because many nurses are interested in this topic, *The Canadian Nurse* sent a reporter to interview the executive director of a provincial nursing association which, in 1964, initiated some radical changes to try to make itself more dynamic, more effective, and more progressive.

Laura W. Barr, executive director of the Registered Nurses' Association of Ontario, has an impressive record in association work. She has been active in chapter and district levels of her provincial association. In 1960 she joined the Registered Nurses' Association of Ontario as assistant executive director and became executive director in 1961. She was instrumental in getting an outside study of the RNAO in 1964 and has been concerned with implementing the recommended changes in the structure of that association.

As a provincial executive director, she attends the board of directors' meetings of the national nurses' association, and she is Canada's representative to the International Council of Nurses' Professional Service Committee. She is extremely competent to talk about the problems and pressures in the growth of a professional association.

Here are some of her responses to questions on the professional nursing associations and their present and future roles.

What are the roles and purposes of a voluntary association?

I believe there are three general purposes in a nursing association. It is a professional association, so one component is to see that the member becomes most effective as a practitioner. Part of the programming has to be concerned with the development of the individual member and with provision of services for the individual that can be better supplied through a group. Then the second emphasis must be the promotion of the profession itself to make it a realistic contributor to society. The association

Miss Zilm, now a reporter for The Canadian Press, was formerly assistant editor for *The Canadian Nurse*, and before that a nursing instructor.

sets standards in excess of those currently in practice, interprets the profession, and attempts to change the course as indicated. The third element is the responsibility to the community at large. The association is the liaison between community needs and professional service. The key to any association has to be balance. Associations sometimes forget to emphasize balance in their programming. To create a balance between these three is difficult, but I believe it is the secret to a useful organization.

One of the difficulties in interpreting the association's role to the membership is the need to interpret the balanced program. There may be a large segment of the membership who are quite young in the profession and really have a lot of personal needs that they want met. They would want the association to put greater emphasis on the first role. Then there are other members who have become quite job-centered; these may be the 25- to 40-age group. They are highly career-oriented and they see a need for a different emphasis. And then there are the ones who have moved out of the profession a little bit and are much more aware of what is going on in society. They see the emphasis as being on community needs. So, an association has to be conscious of the stages of individual development in membership depending on career opportunities, career plans, and age.

Would you say that the third function – responsibility to the community – is what separates a professional association from a union?

Union leaders would say that they also have the interest of the community in mind, but I do think that the professional association has a greater responsibility or commitment to this balance of activity.

Especially in relation to this third function of associations – that of responsibility to the community – isn't the government really the responsible body? Doesn't it act for the community through legislation and health departments?

The government responds to the needs of the people, and it has a variety of ways of having legislation administered. I suppose its main responsibility related to nursing is the legislation of registration, which takes in the approval of schools of nursing, the registration itself, and the discipline. Governments provide legislation for these things.

In most provinces the government has said to the professional nursing association, "You administer these regulations." In Ontario there is a separate body set up to administer the regulations. Ultimately, the responsibility is the government's; it has merely delegated the administration of nursing legislation to a council of nurses which is elected by nurses.



"Members, through the association, set goals for the profession."

But, don't associations have higher standards than the ones governments legislate?

What we find is that the legislation sets minimum standards and the profession, through its association, tries to increase the standards. Many schools of nursing require more than the minimum entrance requirements, give much more than the minimum in the curriculum, and require much more during the nursing program than the minimum registration examination results. Members, through the association, set goals for the profession to work toward.

This explains one of the binds that occurs when the association also administers the regulations. When RNAO did this it was really difficult to be in a meeting for registration one day and be talking about the minimums and then the next day coming along to a member's meeting and talking about maximums. You were almost battling with yourself.

The whole process of registration is to ensure that the public has someone who can be designated as a registered nurse. It is really a protection for the public.

The association says what standards it thinks can be attained in the foreseeable future! The legislative body says what is essential here and now. And somewhere in between the members are working from one to the other – and you have them in all stages of commitment in working toward the goals.

What are nursing's goals right now?

In our province, and I would think this is true right across Canada, there is a great

deal of concern about *how* associations set goals for nursing. This is because the picture of the whole system of health services is unclear. We attempt to put out feelers about where nursing should be going, who the practitioners should be, and what their role should be. It seems to we have not worked enough with other groups. We need to be involved in developing a comprehensive system of health services, of health care.

In Ontario, our association has recently had one conference with other groups to try and come up with proposals for government that will be incorporated into a whole system of health care.

I can remember when I first joined RNAO. As nurses, we were so bent on devising a strong identity for ourselves that we refused to entertain approaches from other groups – except on our terms. For my money we are now making a beginning in interdisciplinary cooperation, but there is still a long way to go. Social workers, physiotherapists, architects, even engineers are coming in to see if they can talk with us at the association level. We even have approaches from the medical profession.

At this conference I mentioned, I met an optometrist. We were talking together and he said, "For me at this conference the eye-opener is that nursing and medicine do not talk the same language. I thought you people were hand in glove and our health care needs were piloted by these two groups in close cooperation. Yet now I see that there is much that you do not understand about each other." He was most disappointed.

If we are going to utilize fully the contribution of the profession, we must work with the allied professions. We can not be clamped into a corner in the way we function. We really can not be effective workers unless we do work in cooperation.

In the past, nurses first joined together in associations to get registration – legislation to protect the patient and the nurse. We were a long time in getting it. After that, the associations stressed the development of nursing education programs, and that has been a long hard haul. As a member of the profession I am awfully disappointed that we failed to do more work on nursing service prior to the time we introduced the general duty nurse or general practitioner in nursing. I think we have a great deal to undo in the way this group of practitioners has developed and the attitudes they have about themselves and other's attitudes about them. Our present goal must be in the area of the practitioner.

In the past the associations have had a great deal of concern about the public and the student, but this was not offering the balanced program either. Now we must concentrate to a greater degree on the practitioner. The primary goal must be to make her the most effective health worker she can possibly be. I see associations as really zeroing in on nursing practice and assisting those in nursing service to develop an appropriate design for the delivery of care.

Studies of voluntary organizations show that membership is usually lower among younger age groups – those that you have indicated would be primarily concerned with the individual.

I think when we are talking about nursing organizations there are some other factors to be taken into consideration. When it has come to looking at the needs of the organization, I have found a tremendous change in the way new graduates look at the profession in the eight years I have been with the Registered Nurses' Association of Ontario. Historically, we are very much geared to our own school of nursing, our own hospital. I question that in the past nurses had strong professional realizations.

Our association is terribly encouraged this year with the high degree of interest and commitment in the newly graduating students. Whether they will all be members or not remains to be seen, but they are tremendously concerned with what the profession should be doing for itself. They have certainly explored RNAO's roles and whether they decide they are effective enough remains to be seen.

Over the years, I have seen a tremendous change in the professional identification of the graduate. Instead of identifying with an individual school, she identifies with the profession.

How do you feel about voluntary and compulsory membership?

I have some ambivalent feelings about this issue. If I have a bias it is toward voluntary membership in an association.

I question the idea that if an association represents all the nurses it has a stronger voice. This concept carries no weight with our provincial government. If membership is compulsory, the government questions whether or not nursing is a profession. One of the responsibilities of a professional is to be organized, to establish standards for his work in conjunction with others of his profession. If we legislate that nurses have to belong to the professional association, then no one will ever know whether our members are responsible professionals, whether there is a core of integrity. If an association cannot maintain membership without being compulsory, does it really represent professionals?

Conversely, I become extremely concerned when there are people who want to be called registered nurse but who divorce themselves from any contact with the profession. Also, an association to be effective needs money, and compulsory membership provides money.

Why would or should nurses join a voluntary association?

When a nurse has taken her two-to-four years of nursing education, when she has committed herself to this field, she has made an investment in nursing. She has made a considerable personal contribution to her career as well as a real financial outlay. Membership in the association is a kind of protection for that investment.

Another reason – although it may be a hard row to hoe – is that through her association the individual nurse can get group pressure brought to bear on concepts that she wants to see developed.

How does a nurse who holds a minority opinion get the whole large association to listen to her? How can one nurse challenge the "establishment" in an association?

One change I have seen in my 10 years with the RNAO, and one that encourages me very much, is the development of the art of debate. In the past we have often had very passive annual meetings; in the last couple of years we have really seen a group of people coming forward to propose and defend new points of view. These new "debaters" can also accept a view put forward by others and still discuss the merits or demerits. We are learning that one or two persons can persuade a large group if they use logic.

Another way the individual now challenges the establishment is through the use of resolutions. Ten years ago there would be one resolution – the courtesy resolution thanking the hotel and speakers. Now at annual meetings our association has 30 and 40 and even 50 resolutions coming forward from members, from individuals who want to question a point, or raise a new idea.

The third way is to raise a matter at the chapter or district level and see it

filter up to the board of directors through the elected members and even to the annual meeting. Election of the board must be handled in such a way that it reflects members' wishes. A good "mix" of members will ensure that the interests of most are considered.

Associations have become much better about seeing that there is two-way communication, because this is one of the essentials if an organization is to survive.

What about the "passive" member as opposed to the "active" member?

I think we will always have people who will be strong, silent supporters. Our province recognizes and awards the title "Member Emeritus" to anyone who has been a member for 40 years. Often these poeple will say "Oh, but I've never done anything. I've just been a member." Yet think what a fantastic contribution this person has made! Moral and financial support for 40 years! All though the depression! It is a problem for me to consider these persons as "passive" members.

What about other ways to contribute?

Belonging to an association gives the individual nurse an opportunity to take her turn to contribute by being a leader. Associations have a structure, like the chapter executive and so on. In a strong organization, these positions will be rotated through the membership so that many people can take a turn at giving an extraordinary amount of themselves for a short period.

In the past, organizations sometimes made the mistake of letting the same persons take the leadership positions for a long period of time and made no allowance for change and sharing of responsibility. People felt hurt if they were not reelected or reappointed. This gave the idea of the establishment. Several provinces, Ontario included, have new structures that encourage rotation through the positions. We are trying to draw many more people in.

However, we still need those strong silent supporters, those who come to meetings, who are warm and receptive, who welcome new ideas. There is a place for everyone in the Association; each one has a special role and a special time. There is a role for the agitator, the activist, the non-verbal supporters, the extraordinary leader . . .

What about the person who does not become a member?



"If I have a bias, it is toward voluntary membership in an association."

One of the things associations have to recognize is that people have different priorities at different times in their lives. Most nurses are females and it is therefore to be expected that at certain times, as during the time they are having children and the children are very young, that the professional association may be low on the list of priorities.

Associations may have to take a more realistic approach to the young members and not expect them to become leaders right away. These young women may need time to find a job to their liking, to become proficient practitioners, to gain confidence in themselves, to take that trip to Europe. But I hope that they will be enough committed to their profession to contribute non-verbally and financially. They should at least allow themselves the opportunity to participate if something about which they have strong feelings comes up.

The young mother, depending on the circumstances, may not see the professional association as a high priority either. She may not even be able to contribute financially – although $35 a year – 10 cents a day – does not seem like very much. We have to accept the priorities set by the individual.

However, associations are noticing quite a different attitude among today's new graduates. Professionalism is of higher priority now than I have ever seen it. The new graduate, even if she leaves her career for travel or motherhood, sees herself as someday returning to the profession and she recognizes the need to build her profession for her future. And when she comes back to the profession today it is with a different attitude. Perhaps our society is changing its attitude toward the working woman, and the working woman's attitudes toward her career are also changing.

There are a lot of contributing factors. One is that women no longer see themselves as withdrawing from the job as they used to do. Then there is the new emphasis in nursing education programs: present curricula expose students to the profession, its history and trends, and current problems. There is a real effort to talk about the present influences on nursing and the student finishes her education aware that there are threats to the profession if she is not involved. Too, there is less emphasis on the student's school of nursing as the total identity and more on nursing itself. Finally, today's students have many more skills in organization; they are much more used to associations in their school years.

I believe the association also has a responsibility toward the "non-professional." The RNAO has extended many services to non-members. They are welcome to come to meetings, for example. We hope they will see some of the benefits of membership. We try to communicate with them about the needs of the profession.

What about associate fees or reduced fees for those who place a "low priority" on association membership?

A good many people have expressed a need for this kind of fee. Those who place RNAO on a low priority do not mind that their privileges from the association might be less if they pay a reduced fee, but they want to be part of the profession. The RNAO discontinued its associate member fee in 1964, but this year at the annual meeting, we reinstated it.

Are professional fees that high? Are reduced fees necessary for those who are not working?

No, I do not believe so. I think we have an attitude toward the income of the nurse that is left over from the past. You still hear nurses talking about being so badly underpaid that you would doubt that they could support themselves. This no longer is true. When our association raised the fees, it raised them from $20 to $35 a year. At that time, mainly through the association's efforts at collective bargaining, salaries had increased by $125 a month. Does it seem unreasonable that out of a salary raise of $1,500 a year a nurse must pay $15 a year more to her association?

A look at membership fees for other

professional associations shows that nurses' fees tend to be low – especially when you consider national and international affiliation fees are included. At the salaries nurses are earning now – something in the neighborhood of $125 a week – I wonder if $1 a week is too much? Personally, I think it is not too much to invest in your professional association.

But just what does the professional association do for its members?

Sociologists point out that professions have three responsibilities: to enlarge the body of knowledge that the profession is based on; to press for higher standards of personnel, education, research, and practice; and to formulate goals. I can only answer this question by saying why I join and support my professional association.

First of all, I believe in nursing. I want it to go on. I see the professional association as the group identity or image for the professional.

As well, professional associations provide the means whereby leaders are brought forward. Professional associations are concerned with promotion of the profession, protection of the members, and policing of the standards. The association speaks with authority for the profession, it can take stands on public issues and provide cohesiveness in actions. The professional association also provides a sense of identity for its members; it gives a sense of accomplishment, a history.

I also see that it may serve as a kind of pressure group to allow us to bring pressure on governments and other groups. The professional association should set the goals based on the understanding and the knowledge of members and unless I participate in the group, it cannot know how I believe.

I want to belong because a professional nursing association today provides many services to the members – special interest groups so that nurses in one specialty can meet with others of the same interest, legal services to members, special kinds of insurance, professional development and collective bargaining services, to mention just a few.

I joined my professional association because to me it is important and meaningful to demonstrate that I care about nursing and nurses. Nursing is important. Nurses are important. The fact that we care is important.

In talking about the association you noted that professional nursing associations' goals have changed from 10 years ago. What do you see for the future?

First of all, today the emphasis is much more balanced. In the past, the individual member of the profession was, to a high degree, ignored. Now, associations are concentrating on this area so that there will be a more effective practitioner.

New goals for the future should be, I think, short term goals. The first, as I have already mentioned, is to help the individual member be a more effective member of her profession. We need to examine how she will be able to articulate, be involved, contribute, and gain.

I also believe that associations are going to have to look at education for the practitioner. We are going to need to go into this whole question of increasing the competence of the individual nurse and of offering continuing education in specialized areas. I see nurses with different competences being developed in three- to six-month postgraduate courses. Some nurses are very fearful of this trend and say that we are developing separate categories. I see it as a need. How are nurses going to keep updated in everything between now and 1990 – when the first hospital will go into space – unless we provide special educational opportunities? We have said that 80 percent of our practitioners will come from the diploma programs. Well, unless this diploma person is kept updated in the special skills that make her an expert in giving direct ongoing care, she is going to cease being useful.

I also think our emphasis in the next 10 years is going to be on nursing practice – affecting the quality of nursing care delivery, increasing the competence of nurses in specialized areas, attempting to help nursing education and nursing service communicate in a meaningful way.

Maybe my other concern about the nursing practitioner has been included in these goals, but I also think that associations will have to help the total profession see a meaningful role for the general practitioner. The general duty nurse has moved into a field that 20 years ago was staffed by students. Many of the attitudes that we had about students giving patient care were transferred to this new, well-prepared practitioner. We did nothing to evaluate the structure in which she worked. This structure is even tighter today, even more binding than it was. There are more head nurses, more supervisors; we have got our practitioners boxed in so much that it is hard to see their role. At present, the individual nurse can influence her environment very little and yet we know that a professional person should be able to influence her environment, to change the plan of care if it does not meet the needs of the individual patient.

I get concerned about the way the staff nurse is involved in providing learning situations for students. We are critical of the bedside nurse because she fails to develop nursing care plans or set up long-term goals for patients. I really wonder how she can, when any day of the week an instructor can come along and say to the head nurse, "I need these kinds of experiences for my students so I will take this patient and that patient! " The next day that general practitioner is reassigned and loses contact with a particular patient.

Rarely do you find an instructor talking to a general duty nurse about her plans for a particular patient. Rarely do you find an instructor asking the graduate which of three ways might be best for the care of the patient: allowing the student to have the patient on her own; allowing the student to work with the graduate while the graduate is giving care; or recognizing that it is not appropriate for the student to give care to the patient at this time because of his particular needs.

A change in the attitude toward the bedside nurse would raise her practice to levels at which we almost do not believe she can function – but she would surprise us. We really need to see her as a professional practitioner. She needs the recognition. This is one area where professional associations are just beginning to work.

I also think that the nursing association are going to become more involved in establishing a system of health care in collaboration with other health professions and governments. This will also involve an assessment of the role of the nurse and how she relates to the other health workers. Under what circumstances will she provide the direct care and under what circumstances will she provide supportive aid to other members of the team? Associations will have a major role in relating to the other members of the health team in establishing the roles and functions of the members. We can no longer plan unilaterally. □

Peruvian adventure

Each year many young Canadians travel to remote areas of the world to share their knowledge and talents with those in less fortunate circumstances. A graduate nurse provides a glimpse of life in the Peruvian sierras and explains the philosophy that led her to embark on this adventure in living.



Peruvian mother nurses her baby.

Danielle Daveluy

Many months have gone by since that frosty February morning when I left Montreal, feeling both excited and anxious about the future toward which the big DC-8 plane carried me. As a Canadian University Service Overseas volunteer, I had embarked on a new kind of life.

That evening we reached Lima, basking in the heat of mid-summer. I had come to this city to study Spanish – a language that I would have to use for the next two years. The Peruvian government, acting through CUSO, had chosen me for this assignment. I was to be posted to the Centro de Salud in Abancay, the capital of the province of Apurimac in the heart of the sierras.

A journey to remember

Six weeks later, although still far from fluent, I set out with another Canadian nurse on the journey to our little corner of the Andes. To reach it we had to go through Cuzco, the archeological headquarters of Latin America. Historically, this city goes back to the age of the Incas. Relics of a civilization that continues to excite admiration still remain; at the same time the beauty of the present-day Cuzco – its architecture, sculpture, and handicrafts – fascinate the visitor. We would have liked to collect samples of everything we saw – colorful ponchos, vicuna wool carpets, little statues of Inca gods, tiny silver llamas.

What a trip we had from Cuzco! It was the rainy season and during the night a large rock, loosened by the downpour, crashed down the mountainside and completely blocked the one and only road. To get around it we had to go on foot, carrying our luggage, almost to the bottom of a ravine, across a little river and up a slope to the road where a bus from Abancay had come out to meet us to take us to the hospital.

Cuzco is only about 125 miles from Abancay, but it took 12 hours to complete the journey! We reached our destination at 9:30 p.m. in pitch-darkness. We were to go to the hospital at the other end of the town, but the bus driver refused to take us and there were no taxis. So there we stood – two strangers surrounded by 10 pieces of luggage, in the middle of a poorly lighted street, in an unfamiliar town, and with only a meagre knowledge of the language.

A little boy watching us pointed out a telephone just opposite to where we were standing, and we went over to it. About 20 Indians sitting in a little house nearby watched in complete astonishment. On the phone, we tried in vain to explain our

Miss Daveluy is a 1967 graduate of Maisonneuve Hospital, Montreal.

A street in Abancay, capital of the province of Apurimac in Peruvian Andes.



arrival, but no one could understand our gibberish. Finally a young girl who had been listening to us came to the rescue and helped us explain our predicament – with success. Five minutes later the hospital ambulance arrived with a flourish to collect us.

A valley high in the Andes

Abancay is a small town situated in a deep valley, 7,000 feet above sea-level. It has a population of 15,000. Houses are built of adobe bricks with red tile or corrugated iron roofs. The people are half-breeds – the offspring of unions between the conquering Spaniards and the native Indians. The Indians themselves live in the mountains, far enough away that sometimes a two- to three-day walk is necessary for them to come into town.

The 150-bed hospital is new and completely furnished with German equipment. It has a medical staff of eight doctors and six nurses – four of whom are members of a German religious order. About 20 auxiliary workers, men and women, complete the personnel.

I was assigned to the surgical ward – a 40-bed unit that rarely has more than 30 patients. In addition to general surgery, we also care for patients admitted to neurosurgery, ophthalmology, otorhinolaryngology, and pediatric surgery. There are many burn cases and dermatological conditions here also.

Sometimes we even have mothers who have to have Caesarean section, or women with gynecological conditions. There is much to be done, not only as far as patient care is concerned, but also in relation to educational programs for patients and auxiliary workers. Occasionally I must take my turn in the operating room when major surgical procedures are scheduled.

Beautiful black-eyed children

Generally the patients are peasants – impoverished, dirty, and illiterate. On admission the children look terrified and defiant but in about two days time you can win their confidence and their smiles. They are lovely youngsters with big, black eyes, tanned skins, and thick black hair. When they smile at you, it can make your day. Unfortunately, the dialect that they speak, which was inherited from their Incan ancestors, is hard to learn – which makes communication with them rather difficult.

For the first few days I found life rather discouraging. Every time I gave an intramuscular injection, I broke the needle. The Indians have very tough skins! Now, however, I am used to this and the results are better. Quite often we are short of drugs. As a rule the hospital supplies them as few patients can afford to purchase their own. Even solutions are lacking once in awhile, and as for intravenous equipment, when there are no more sterilized sets, we boil used ones and make the best of a bad situation.

On the evening of my arrival in the hospital, I had been intrigued to read a sign on one door: "banco de sangre." I opened the door and there was the blood bank – an undraped stretcher, an empty refrigerator, a tourniquet, and some alcohol sponges. And that tells the story of blood donations in this country.

Upper class patients have no problem. Auxiliary workers and even the doctors will happily part with a pint of their blood since they receive $15 per transfusion. Alas, when a poor penniless Indian needs blood, all of the auxiliary workers disappear. Fortunately, about 90 percent of the persons on whom blood grouping is done are universal donors.

A fatalistic outlook

These people are extremely fatalistic in their outlook. Many die alone in their little cabins, without coming to the hospital or seeking medical attention because they feel that if their number has been called, no one can help. They believe that it is their fate to be poor, ignorant, and sick and so they do nothing to try to overcome their disadvantages. This fatalistic mentality is carried on from generation to generation.

My friend was put in charge of the maternity service, which included both obstetrics and gynecology. Indian women of all ages, some barely 15 years old, have their babies easily without anesthesia or midwife assistance. In cases of home delivery, several mothers usually appear at the hospital about a week later with complete or partial placental retention. Almost all curettages are performed without anesthesia.

A great many children are admitted suffering from a type of malignant hepatitis peculiar to Abancay. The cause is unknown. All of these children die after one or two days of delirium and convulsions.

Other children are hospitalized with malnutrition – qualitative and quantitative – of varying degrees of severity. Since they eat only soup and rice, protein, vitamin, and mineral deficiencies are common. Mothers breast-feed the children until they are one-to-two years old (or until another baby comes along); the mothers, too, are undernourished.

Tuberculosis in all forms is prevalent in the sierras, affecting adults and children alike. I have encountered two patients with tetanus already. One man was brought in with an open fracture of the leg that was simply crawling with maggots. I have seen children following appendectomy vomit tape-worms about 10 inches long. I have seen a man come to visit his dying father accompanied by a tailor who proceeded to take measurements for the burial suit.

On a less serious note, I have tasted beef stomach and tripe soup (which we have once a week at the hospital) and, believe me, our good old pea soup then looks like food fit for a king.

In contrast to this rather sombre picture, many patients leave hospital cured and with a smile on their face. They are the majority.

Pros and cons

Even after all these months, it is hard for me to define the motives that prompted me to leave friends, work, and country to come to an environment so different from everything I had known, and to work under frequently difficult conditions. What has been accomplished during the past two years will not be lost, but what of the future after I leave?

As soon as I turn my back, the auxiliary workers will forget all about asepsis and even ordinary cleanliness. They will become negligent, impatient with the Indians, as soon as I am no longer there to supervise them.

I know, too, that the patients whom we have cured through faithful care will return again suffering from something else, or they will die in their homes because they failed to return. For what or for whom has the past two years of effort been made?

One answer to this was provided by a volunteer worker in the mission. He pointed out that those whom I had cared for, helped, and loved would, in all probability, not have received such attention otherwise. Perhaps they believe now in the brotherhood of man. If even a handful of people are warmed by this thought, my time in Peru will not have been in vain.

Another answer is found in the CUSO motto: "Volunteers learn while serving." They learn that man, regardless of climate, color, financial standing, or learning is still man, sharing the same great emotions – love, hate, fear, anxiety. Wherever he may be in the world, whatever may be his culture, the color of his skin, or his mentality, he is worthy of being loved. □

Family health service: the PHN and the GP

In January 1967, a special research project began in which public health nurses worked with private doctors to provide better care for patients. In July 1968, an article in The Canadian Nurse described this project. This article reports on how the project has developed.

Phyllis E. Jones and Doreen M. Bondy

A private practitioner was having a problem with a family under his care. A 20-year-old, multi-handicapped girl in a wheelchair was living with her parents and two younger brothers. All were depressed by the situation and many were the visits and phone calls made by the doctor.

The parents of the young girl said they wanted her placed in a suitable institution; the girl herself agreed this would be best. However, all were troubled. Was this the best solution? And, besides, just what kind of facilities were available?

This doctor turned for help to a public health nurse who worked with him. She, too, began visiting the family.

The doctor and the public health nurse pondered the question together. They discussed various possible solutions. Finally, they decided that, because the family had previously attended the Mental Health Clinic, the clinic personnel should be consulted about this new crisis.

A clinic psychiatrist visited the home. Although the nurse was not able to go to the home with the psychiatrist, she met him shortly afterward to discuss the patient's situation. During the discussion, she invited him to come with her to see the family doctor.

As a result, the family doctor and the nurse did the counseling of the parents and the girl under the guidance of the psychiatrist.

Eventually, the young lady was admitted to a hospital for the chronically ill. The nurse visited her there after she was admitted and found her happy and animated, enjoying the companionship of her roommates, and interested in her occupational therapy program. She met the mother, too, during that visit and scarcely recognized her without the one-time haggard look. All this was achieved through the guidance and support of a *team* of private doctor, public health nurse, and community psychiatrist.

No fairy tale

This kind of cooperation really exists. It is just one example of the coordinated effort facilitated by the presence of the research project nurse.

The project,* jointly undertaken by the Borough of East York Health Unit, the University of Toronto School of Nursing, and six general practitioners, was designed to use existing public health and private medical practice arrangements with only minor modifications. Public health nurses employed by the local health unit were assigned to work with designated private physicians and to provide public health nursing service to families receiving medical care from these physicians.

This project was designed to explore one way to close the gap in communications between two community health workers — the public health nurse and the general practitioner. Both have the same focus of interest: the health of the family. The overall aim was to examine the feasibility of seconding public health nurses employed by a local health department to work with designated general practitioners. To achieve this aim, three objectives were stated: to determine the cost to the agency of assigning public health nurses to private medical practice, to examine requirements for nursing service of patients receiving medical care through private general practitioners, and to identify factors contributing to communication between private practitioner and public health nurse.

A previous article included some preliminary observations and posed some questions about the project.[1] This article updates some of the findings and observations and discusses some of the implications — such as the relative responsibilities of the family doctor and the community nurse within the framework of present conditions.

*The project was assisted by a Public Health Research Grant.

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Mrs. Bondy, a graduate of the Royal Infirmary, Aberdeen, Scotland, is a public health nurse with the Borough of East York Health Unit.



The elderly account for a high number of referrals, and often are most in need of care.

Evaluating the project

During the two years the project has been underway, three general practitioners and one public health nurse have been involved full time and an additional three general practitioners and one other public health nurse have participated for shorter periods of time. These variations resulted from changes in personnel during the life of the project.

Sources of data include the referral form completed by the physician for each request for nursing service; the nursing service record for each family; an analysis of a sample of nursing time and activity; and comment from participants.

During the two years, 484 persons were referred by the doctors for nursing service. This represents an average of 60 referrals per year per doctor. Analysis of this total by selected age groupings reveals that more than three-quarters were adults over 20 years of age, and only 14 percent were under school age. *(Table I).*

Medical findings associated with referrals for nursing service were classified using the International Classification of Diseases.[2] This revealed that the largest number of total referrals, 38 percent, were related to maternity; 26 percent prenatal and 12 percent postnatal teaching. This explains the large proportion of patients in the 20- to 44-year-old group in the table. It also means that there was a much greater nursing contact with infants than the table suggests, since mothers referred during the prenatal period had nursing supervision postnatally for as long as required.

The prenatal and well baby referrals were a source of great satisfaction to the public health nurse. Knowledge of the doctor's routines and expectations made her teaching more meaningful. The patients were very accepting of their "doctor's nurse" and frequently called her directly. One of the earliest referrals for nursing service was to an expectant mother who was failing to keep her appointments. She has become a "regular customer" and recently even called the nurse when she was bleeding heavily following insertion of an intrauterine contraceptive device. The nurse reassured her, then hastily called the doctor for her own reassurance!

Twenty-two well preschool children were referred to the public health nurse for guidance in normal development and behavior. If these are added to the group of expectant and new mothers, it means that 43 percent of referrals were for nursing service to essentially well individuals; it also means that a large group of young families had access to nursing supervision over a period of weeks or months while learning new roles and skills in family life.

The elderly also accounted for a high proportion of referrals. As will be seen in the table, 27 percent of patients were over 65 years. It is not surprising, therefore, to find that the medical findings, other than maternity and preschool, show relatively large proportions classified as mental and personality disorders (11 percent), circulatory diseases (8 percent), diabetes (6 percent) and senility (6 percent), all commonly associated with aging.

Reasons for referral of the elderly varied from short term needs, such as making arrangements for homemaking services and supervision of medications in acute illness, to long term needs, such as helping prepare the patient for more sheltered care in a nursing home, chronically ill hospital, or home for the aged. Discussions between doctor and nurse fostered close collaboration, not only in the approach to the patient who so often is unaware and unaccepting of the need for more care, but also in making appropriate arrangements for care.

TABLE I
Referrals For Nursing Service, 1967–68: According To Selected Age Groups

Age Group	Number of Referrals	Percentage
Under 1 year	35	7.23
1 – 4 years	34	7.02
5 – 14 years	18	3.72
15 – 19 years	22	4.55
20 – 44 years	196	40.50
45 – 64 years	49	10.12
Over 65 years	130	26.86
	484	100.00

Other types of referrals included those to newly diagnosed diabetics (about 6 percent of total referrals) and to pre- and postoperative patients. These people have been well counseled by the doctor, but because of their emotional turmoil often experience further confusion and anxiety at home. This anxiety is alleviated by an early nursing visit during which needs can be anticipated and questions answered.

Liked by all participants

In the opinion of the majority of participants, the greatest value of the project to patients has been the teaching and counseling function of the nurse; this has led to greater assurance on the part of the patient in carrying out his medical regime. Participating doctors found that these functions were also of value in their management of medical care. Also noted by the majority of doctors as useful was the increased knowledge of the family and home situation brought to them by the project nurse through her skills in assessment of health and related problems.

An important part of the project nurse's function could be classified as liaison or coordinative. Her knowledge of community resources and how to mobilize them was constantly used; in fact, about 7 percent of project nursing time was devoted to consultation with other agencies and with co-workers on behalf of patients. The case story of the multihandicapped girl given at the beginning of this article is but one example of coordinated effort.

Referrals such as mental retardation in children, alcoholism, mental health or marital problems were likely to require the service of other agencies. The doctor might want more detail about the agency's policies or the nurse might suggest an alternative service or arrange to gather more information.

Because of these discussions the doctor and nurse sometimes decided that a home visit was not indicated at that time. Alternatively, such as with the elderly person who had called the doctor's office confused about the taking of prescribed medication, a visit from the public health nurse was frequently more appropriate than the doctor's house call.

Although the project was not designed to measure the effectiveness of the resulting service, in the judgment of all participants the closer working relationship between these two personal health care workers was of value to patient care. The consistent communication between the physician and the nurse allowed an exchange of ideas and a pooling of their assessments of the patient, the family, and the social situation. This led to a more concerted approach to the management of health problems.

Joint planning activity, together with the nurses' skills in teaching, assessing health needs, and mobilizing and coordinating community resources, permitted the doctor to extend his treatment of patients. In the words of one doctor: "In certain areas, the quality of medical care has been improved because of better continuity and because of an increased emphasis on social and preventive aspects of medical care as provided by the visits of the public health nurse."

The interchange between doctors and nurses necessary for this joint planning activity was readily achieved through regular weekly face-to-face discussions, through ready doctor-nurse accessibility at other times, and through sharing of medical and nursing records. Approximately 10 percent of project nursing time was spent in these activities of relating to the doctor and his office and records. Doctors estimated that conferences with nurses required about 45 minutes to one hour per week; they believed that this was more than made up by the efficiency with which certain problems could be handled.

Other factors indicated that this investment of time may have resulted in an overall saving of time for doctor, nurse, and patient: doctors noted that telephone calls from anxious patients decreased when there was contact with the nurse; house calls or home visits by doctor and nurse could be planned to complement one another; and, when families had the doctor's orders explained and reinforced, they were better able to accept these and take action sooner.

Implications of the project

These observations, selected from the findings of this demonstration, suggest that a significant part of private general practice can benefit from appropriate public health nursing skills. No new tasks were added to the public health nurse's function except that of working as a colleague of the doctor. All participating doctors employ office staff with varying background; this office staff continued to assume responsibility for managing the office and assisting the doctor just as they had done prior to the project. Relationships between office staff and public health nurses were constructive and helpful. The one dimension that was added by this project was the closer doctor-nurse working relationship.

The nursing functions of teaching, counseling, assessing, and coordinating were judged to be of value to the patient and family and to their medical management. For definitive answers to the vexing question of relative effectiveness and resulting costs, much more study is required. However, in the light of present knowledge and conditions, it seems likely that increased collaboration between private doctor and community nurse is both possible and highly desirable.

The findings that the public health nurse's skills were most used in dealing with the expectant and new mother and in the management of illness of a long-term nature are not inconsistent with the findings from other sources.[3-6] These two groups make up a large proportion of the population and account for a large part of the utilization of health care services. Since much of the management of the health problems of these two groups involves measures aimed at maintaining health and preventing further illness and complications, public health nursing skills seem very appropriate for this aspect of ambulatory or out-of-hospital care. It seems likely, too, that the public health nurse's "family advisor" functions and her knowledge and preventive approaches can be most effective if closely aligned with the family doctor's skills in clinical medicine.

The change made by the health unit – that of assigning one public health nurse to work with the patients of a number of doctors rather than to a territory – was the largest factor in making communication easier between the private practitioner and the public health nurse. It is equally clear that the consistent contact between these workers has vastly improved their communication.

Whether or not formal arrangements exist for these closer working relationships between the private doctor and community agencies such as the health department, better communication between individual nurses and doctors obviously can do much to complement their work in providing health care in the community.

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Helping the patient face reality

How ridiculous to assume that a nurse can don the cloak of a psychiatrist, social worker, or psychologist and intensively counsel patients with emotional conflicts related to their illness. However, recently an opportunity to work with a medical patient helped this student see this grey area of nursing a bit more clearly.

Gail A. Arnold

Preparing to live with a medical condition, or facing the prospect of a shortened life expectancy, forces patients to undergo varying degrees of psychological stress as they struggle to cope with the reality of their altered health status. In this situation, it is most definitely a nurse's responsibility to help patients make this difficult adjustment.

I was working on a medical floor where hospitalization is lengthy and where doubts, fears, and anxieties almost invariably affect an individual's health. This opportunity helped me to realize my role as a therapist intensely involved with the emotional conflicts as well as the physical aspects of patient care.

My patient was a 53-year-old Irishman who had had tuberculosis 30 years ago and a recurrence one year ago. He had a history of bronchiectasis, and his more recent condition was emphysema.

The present hospitalization was initiated by a severe dyspneic attack and while in hospital he had undergone a glomectomy (carotid body excision). Although the reason is unclear, removal of this chemoreceptor respondent to oxygen, carbon dioxide, and p^H blood levels has, in some instances, been known to relieve dyspnea. In this situation, however, no positive results followed. When I was assigned to Mr. Smith,* it was five days after his operation and he was waiting for transfer to a chronic hospital.

*Pseudonym

Observing

Before I ever met my new patient, a picture had begun to be formed. Most certainly, we should rely on the patient himself for our perceptions, but often the concepts that contribute to the picture begin with the observations at the desk.

How does one observe? I suppose that our eyes see and our minds make little notations; often the notation does not reach our conscious thinking until further evidence is brought to support it.

My observations of Mr. Smith's case went something like this.

Reading the Kardex: emphysema – could be caused by allergy, infection, emotional factors; unsuccessful glomectomy – a serious disappointment for the patient; Staff doctor – no family doctor, is he alone? ; occupation writer – intelligent, emotional, sensitive.

In the hall: stopped by staff member before reaching room: "You'll be lucky if he lets you make the bed. Best to leave him alone." – I had no thought, just two raised eyebrows.

In the room: "no visitors" sign on door – but he was five-days post-operative; clothes on chair (bright greens and blues to be worn together) – hardly the conservative type. . .; clock on table (small white with little red flowers) – hardly a 'Brutus' either; typewriter on overbed table – still interested in his work.

On seeing the patient: lying in bed with no clothes on – I've never had a patient who didn't wear a gown or pajamas.

During the day the picture of Mr. Smith became clearer. He was a short, rather effeminate-looking man with straight, quite long hair that seemed to have been dyed – possibly for acting; he appeared indifferent to company and stated he would rather be alone. He did not want to get up from a "sleeping" position, lying on his left side, curled slightly, his hands under the pillow and his exposed ear always covered with a radio speaker. Whenever I entered the room he seemed to be asleep, but my suspicions asked if he were not merely avoiding personal contact.

He seemed disinterested in his appearance, with no desire to dress, wash, or shave, and refused to be assisted with these. When he spoke, he used affected tones; every statement was dramatized and dashed with a pinch of humor that kept the conversation a breezy distance from serious reality. For each little procedure I carried out (not much more involved than passing him his medication) I was overly thanked, and whether I was speaking or being spoken to, Mr. Smith never looked at me.

Miss Arnold, a second-year student at the Nightingale School of Nursing, Toronto, prepared this article as a patient care study on support for a patient with a long-term illness.

Responding

The most effective way one can relate to another person is to be natural; then genuine interest and honesty are easily conveyed. The natural response to Mr. Smith's "put-off" was to be somewhat annoyed. This then was the basis for my reaction; I was more firm and matter-of-fact, and just as persistent as he was. I thought that in this way he could not help but see that I was not as much interested in his wit as I was in him as a person.

According to Fiedler, the elements that characterize a good therapeutic relationship are an ability to understand another's meanings and feelings, a sensitivity to his attitudes, and a warm interest without emotional overinvolvement.**

Interacting

Since relationships are built upon interaction, I shall try to give you a few significant snatches of our conversation in which I think Fiedler's three elements can be identified.

During my first afternoon with Mr. Smith, I sat by his bedside for about seven minutes while he "slept," then softly said, "I don't disappear until midnight." He alertly opened his eyes and muttered "Bloody leprechaun! "

We talked briefly and he began to continue with "thanking." I said, "Mr. Smith, someday I will discover what you mean when you say 'thank you'."

The next morning we had the same difficulty establishing contact. I reminded him of our bargain from the day before: "I'll find you a hot cup of tea – you let me make your bed," but he "slept" in silence. Snatching the back of his menu, I tried to imitate his prosaic phraseology:

Arise good sir,
Pay tribute to your liege lord nurse.
She maketh tea to come at ten.
Get thee hence upon thy chair
I *will* anew thy linen fair!

I placed this in his hand with his glasses and walked out of the door commenting, "I'll be back here in ten minutes." On my return he was sitting on the chair. "You don't stand for much nonsense, do you, Miss Dragonfly? I hope you don't have any ideas about a great future in poetry writing."

Gradually he made it known to me that he feared being "shipped off" to a chronic hospital. He showed little factual knowledge of his condition other than it being "incurable." Related to this was his frustration at having to be dependent upon the medical profession. He seemed frightened and alone.

Relating

As we got to know each other he still tried testing me periodically. Two mornings he asked me to phone physiotherapy and say he was "not up to going" that day; I did this for him. On the third day when he asked, I showed my unwillingness by asking him to verbalize his reasons. "Okay, okay. I'll go to the damn place! " Thereupon, I picked up the phone and said, "Hello, this is eighth floor calling to say Mr. Smith will *not* be down for physio today."

"What? I just said I'd go! " he interjected.

"Mr. Smith, I don't need physiotherapy. You don't have to do anything for my sake," I replied as I left the room.

The next week he went without a reminder.

Relationships, both personal and professional, are never formed at one given time. Unless they continue to grow and change, they cease to develop and fail to be of any value to either person.

To provide the necessary nutrients for this developing process, there have to be various degrees of interaction on both sides. This is not always 50-50; sometimes, as in a helping relationship, it is 85-15.

Looking back at the physiotherapy incident, I think that for me to have unquestioningly complied with Mr. Smith's wishes would have kept us further away from our goal, to help him take a positive approach to his condition. Although prior to this we had made big steps, it was only a beginning; we were not relating but we had provided a channel by which we could both view our common goal and together try to achieve it. In other words, we were communicating.

It was not until we were both on this road that Mr. Smith could accept a more concrete form of support. This took the form of working out a regime with which he could familiarize himself while in hospital. At a chronic hospital he would most likely be given a more elaborate plan of exercise, activity, postural drainage, and other treatments. The important thing while he was in my care was the establishment of positive goals that he could take with him.

In the apparent trivia of our daily relationships lay the determinent of whether Mr. Smith would be "shipped off" to a chronic hospital, or whether he would instead be going with the desire to make the most of his life within the realm of his capacities.

One afternoon, Mr. Smith accepted my invitation for a walk down the hall. To my knowledge he had not been out of his room for three weeks. He walked the hall twice without dyspnea, visited another patient briefly, and suggested we sit in the lounge. I left him in an armchair with a cup of tea and a magazine and returned an hour later to find him conversing with another patient. Had he not taken a big step from his apathetic attitude of several days ago?

Moving on

Between this time and his discharge, Mr. Smith was given some literature on his condition and his doctor discussed emphysema with an approach relevant to his oncoming plans for entering another hospital.

The morning he was to leave, Mr. Smith was somewhat dyspneic and obviously frightened, but he left with a smile to my wave. I hope he was equipped with a foundation firm enough for him to make a healthy physical and mental adjustment. □



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It's depressing!

There is considerable evidence that being in hospital may cause depression. In this article, a psychologist speculates on the nature of depression occurring in patients in hospital.

C.G. Costello. Ph.D.



It is generally accepted that hospitalization – especially hospitalization for a serious illness – may produce considerable depression in a person. However, the ways in which such depressions may be understood and modified seem to have been neglected in research.

Research has centered on the more severe forms of depression, but, unfortunately, the conclusions of investigations into these severe depressions cannot be extrapolated to mild depressions. Both clinicians and researchers have assumed that there is something qualitatively different between "normal" depression and the depressions of psychiatric patients. Severe depressions have been considered to be due to a disease process of some sort, and emphasis has been placed on somatic treatments. As a result, little work has been done on the behavioral analysis of depression.

Studies of severe depression – of psychiatric depression – are therefore of little use to nurses in understanding the mild forms of depression common among patients on general wards. But it is hoped that the following discussion – of necessity a speculative one – of two theories in psychology might help us to understand the nature of these mild forms of depression.

Dr. Costello is a professor in the Department of Psychology, University of Calgary. Other of Professor Costello's articles – mainly on nursing education – have appeared in *The Canadian Nurse.*

Sarbin's theories

The first theoretical system to be discussed is the one described by Sarbin.[1] He is concerned with the effects of a person's social status and his role performance in that status on his behavior, both adaptive and maladaptive. (The term "status" is used in the sociological sense of being equivalent to a person's position in a social structure.) He distinguishes between *ascribed statuses* and *achieved statuses.* Examples of ascribed statuses are: mother, adult, male, female; examples of achieved statuses are: Member of Parliament, pop singer, voter.

The most important difference between these two types of status is that one does not choose to occupy an ascribed status – or at least the element of choice is small; in achieved statuses there is a considerable element of choice. A girl cannot choose her female status and may have only a small element of choice over her status as a housewife; she can, however, choose whether or not she will occupy the status of a pop singer or an athlete.

A second important difference follows from this one. This difference concerns the evaluations placed on the role performance. The evaluations placed on performances in ascribed statuses tend to vary from neutral to negative. For instance, the housewife, occupying an ascribed role, can be severely criticized if she does not perform her role adequately. On the other hand, she receives very little in the way of praise or reward for good performance of the role. This, of course,

may explain the frustrations experienced by many women occupying the housewife status and seems to be far more likely than the usual one suggested that "her work never finishes." If the interminable nature of the work were the important factor, then one could not explain why many housewives will both hold a job outside the home and also fill the housewife position, and in so doing be much happier.

We can explain this greater happiness of the working wife, if we consider the evaluations placed on role performance in achieved statuses. Here they tend to go from neutral to positive. Because one chooses, for instance, to be a member of a committee (in this heyday of committees the choice even in this regard is becoming increasingly smaller – but that is another matter), poor performance or even absence from some committee meetings receives very little in the way of criticism. Good performance, on the other hand, can receive considerable praise.

There is a third important difference between the two kinds of statuses. An ascribed status involves a considerable period of time. One is always male or female, always a mother or a father. An achieved status, on the other hand, need only occupy us some of the time. Being a committee member may involve only a small portion of our time. Being a nurse is not a full-time job. As a result, one can move from one achieved status to another if things are not going too well. One can also simply pull out of an achieved status for a time as on a holiday. This cannot be done in the case of ascribed statuses.

Occupancy, then, of an ascribed status is something from which we can get little if any relief and also something which brings us little or nothing in the way of reward or praise, but may bring us blame and punishment.

Sarbin has not discussed the relevance of his system for depressive states. His purpose has been mainly to use the theory in an attempt to understand why poor, deprived people have a tendency to have more serious psychiatric diagnoses. He suggests that the cognitive strain involved in occupying only ascribed statuses may be the most important factor. For instance, it is because the youth in the slum does not have a job and therefore never receives praise or reward for an achieved status that he is likely to engage in socially unacceptable behavior.

Implications of the theory for patients

This theory might have relevance in relation to the depression that occurs in people entering hospital. The hypothesis would be that there is a transformation of their social identity. More specifically, the person loses his achieved statuses – at least temporarily – and occupies only the ascribed status of patienthood. It may be argued that a person chooses to enter a hospital, but since admission into hospital is the logical outcome of certain illnesses, in practice there is very little choice.

A person, then, who might have occupied a number of achieved statuses with their potential for rewarding consequences now finds himself occupying one full-time ascribed status with no opportunity for any real reward. Comments by the nurse to an adult patient that he or she is the "best patient she has ever had" are not likely to be considered particularly rewarding. It is likely that comments or indications from the nursing staff that the patient is not behaving as he should are likely to be far more impressive.

It is true, of course, that there can be some maintenance of achieved statuses in hospital. The businessman may still be able to make some decisions concerning his business. One would expect that to the extent that this can be done, the less the probability of the development of depression. The little-rewarding, ascribed status of patienthood is still likely to be predominant in the person's awareness, however. This is particularly so, of course, on terminal wards, when relatives, friends, and business colleages begin to pull away from the dying person.

It might be expected that the depression occurring due to the transformation of social identity would be less for those patients who, before admission to hospital, occupied only ascribed statuses such as the unemployed or aged. Evidence presented by Glaser and Strauss,[2] suggests that nurses are far more disturbed when a person occupying highly-valued achieved statuses is dying. This disturbance seems to be due to awareness of the social loss involved.

Application to the dying patient

The occupancy of a social status implies certain expectations on the part of the occupant and of others concerning the behavior of the person in the status. These are what are known as role expectancies. It is generally known by administrators that confusion concerning the status of individuals in an institution – which in turn results in confusion concerning the behavior expected of the individuals – can present one of the biggest administrative headaches. It might be expected, therefore, that similar problems would result when there is confusion on the part of *either* patient or nursing staff concerning whether or not the patient is dying.

We have suggested that the ascribed nature of patienthood is particularly clear when the patient is dying. Here there is no choice at all and inevitably one faces termination of all achieved statuses. Fortunately, man is able to adapt to his circumstances. It would seem likely that most people can adapt to the thought of dying. Hinton's[3] review of the literature indicates that people, whether or not they are terminal patients when interviewed, would generally prefer to know if they are dying; 80 to 90 percent of the persons interviewed expressed this wish.

Where there is no clear awareness on the part of the patient as to whether or not he is dying and when the nurse is struggling to prevent imparting cues to him about his dying status, not knowing herself just how aware he may be, there is no opportunity for adaptation to any status. This lack of opportunity for adaptation, plus the strain for both patient and nurse and the suspicion and mutual pretense, would seem to provide most undesirable circumstances for a person's last period of time on earth. Nevertheless, Hinton's study also indicates that 80 to 90 percent of physicians are against telling the patient that he is dying. It does not seem that a study has been done on nurses' feelings with regard to this. This, of course, is something that should be done because it is the nurse, spending far more time with the terminal patient, who must bear the brunt of any ambiguities in the situation.

Ferster's theories

There is a second theoretical system, proposed by Ferster, on the way in which depression may occur.[4] His theory also suggests ways in which the depression of a patient may be modified.

Ferster suggests that reduction in a person's performance is one of the most characteristic aspects of the depressed condition. He notes that animal experimentation shows three conditions under which performance may be reduced:

1. *When a large expenditure of effort is needed to produce any change in the environment.* Ferster gives as an example the salesman who has to visit many, many customers to get even a few sales. When the ratio of selling behavior to sales gets too large, he will soon stop trying. Similarly, any attempt of a patient to continue performing his roles in an achieved status after entry into hospital will in-

volve very much more effort and perhaps so much effort that the person will stop trying.

This principle may also help us to understand how depression may result from the illness itself rather than from the status of patienthood. For instance, the person who becomes handicapped through amputation will probably have to put considerably more effort to perform satisfactorily certain behaviors than he had to do previously. Once again the effort may be so great that the person will give up trying.

Certainly it would seem to give us more understanding of the disturbance of the handicapped person to think in terms of greater expenditure of effort required than to think in terms of distorted body images. Seeing the problem as due to a distortion of body image does not provide either the patient or the nurse with the means of alleviating the disturbance. Recognition that increased effort is the important factor enables them both by proper spacing of activities and by maximizing feedback of success to offset the problem to some extent.

2. *When conditioned aversive stimuli precede an aversive event.* It may be worthwhile to consider how this principle can be demonstrated in the animal laboratory. First of all, the animal learns to press a lever to obtain food. When this behavior has become firmly established, the animal in another situation then experiences the association of a buzzer and an electric shock, the buzzer always preceding shortly the onset of the electric shock. In this way, the buzzer soon becomes a conditioned aversive stimulus. If now the animal is put once again into the bar-pressing situation, and the buzzer is sounded, the animal will not press the bar even though it is very hungry. It can be shown that the animal has not forgotten the response of bar-pressing because it will begin to press the bar if the buzzer is not sounded.

It is likely that many of the stimuli for a patient in hospital are conditioned aversive stimuli. These may be stimuli such as hypodermic needles that have been associated with painful sensations. For the terminal patient many of the stimuli may be associated with the approaching death. It is not surprising then that many of the learned behaviors, such as eating, reading, talking, may be suppressed by the presence of these aversive stimuli.

So that these well-learned behaviors can once more be performed, it would seem necessary to reduce as far as possible the presence of any conditioned aversive stimuli associated with the illness. This, of course, is a good argument for the absence of nursing uniforms and any rituals that may serve as reminders of the aversive events.

2. *When there is a sudden major change in the environment.* Ferster reports that under certain conditions a sudden change may virtually denude an individual of all his past learned behavior. "The secluded elderly spinster lady, for example, may lose her entire repertoire on the death of her close companion because each person's behavior was narrowly under the control of the other."

There are obvious links between this principle and Sarbin's ideas concerning the transformation of social identity. It may be expected, for example, that the businessman who has chosen to occupy his achieved status as an executive for most of his waking life will find himself at quite a loss on entering hospital. This is so because his behavior has been determined almost completely by stimuli associated with his position as an executive. Generally, it may be said that the more restricted the stimuli are that control behavior, the greater the loss of behavior on removal of the stimuli.

We can also use this principle in the understanding of the depressions recurring from the illnesses themselves. In the case of an amputee, for instance, we not only have the loss of effective stimuli from those parts of the body now lost, we also have the loss of the stimuli-maintaining behavior in those situations which the handicapped person can no longer enter.

Implications for nursing care

Depression occurring in patients on entering hospitals thus may be best understood as a drastic reduction in performance as the result of changes in the patient's environment. To alleviate the depression, the nurse needs to establish new behaviors in the patient or to elicit old behaviors once more. This may be done by encouraging relatives and colleagues to maintain for the patient some of his achieved statuses.

A patient's skills may be used in relation to a problem in the ward or in the hospital. For instance, the legal skills of a sick lawyer may be used. Stimuli that were previously effective in eliciting strong behaviors should, as far as possible, be introduced into the situation. For instance, the patient who read a lot of history should have available history books rather than novels. The woman who did a considerable amount of knitting should have appropriate materials available. As far as possible, conditioned aversive stimuli should be removed from the situation.

Initially, the development of either old or new behaviors will be slow. The problem is to introduce new stimuli and new positive reinforcers (rewards) to build up behaviors.

Drugs cannot be expected to result in the development of new behaviors though they may influence to some degreee the existing repertoire of behaviors of the person. Ferster has commented, "The effects of drugs on behavior suggest a situation much as with the effects of a drug on cell or organ physiology. A drug can make a cell do more or make it do less, but it cannot make the cell do what it does not do anyway. A kidney will excrete more or less urine under the influence of drugs, but it is unlikely that the drug will make the kidney produce thyroxin."

Conclusions

It would seem that a useful addition to the educational curriculum of the student nurse would be training in a behavior modification laboratory. Whether or not depression is more likely to occur in those previously occupying achieved statuses than in those previously occupying ascribed statuses, is, of course, something that could readily be investigated in the hospital. The nurse, perhaps more than anyone else, finds herself spending long periods of time with people going through perhaps the most stressful period of their lives.

The more that the nurse can learn about the close observation of behavior, its antecedants, and its consequences, the more she can learn about the way in which she could manipulate environmental stimuli to reduce or increase behaviors. Thus the greater her beneficial effects on the patient would be and the more comfortable he would be. In all probability it would follow in many instances that his chance for recovery from his physical illness would also be greater.

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idea exchange



Nancy Dolan, a student nurse at St. Michael's School of Nursing, is shown at the animation stand, illustrating one method of doing title shots.



The stars of "Where It's At" – students and faculty of St. Michael's School of Nursing – were invited to the premiere of their own production.



Mary Pat Byrne (left) is using the "editor" and Maureen McAlpine is preparing to use the "splicer" in the final editing phase of "Where It's At."

Film Crew At Work

Students at St. Michael's School of Nursing in Toronto wanted to make this year's Education Week – an annual event at the school – "different." The result was *Where It's At,* an 18½-minute film made by and about student nurses.

The students were eager to see the school's new Super 8mm camera in action – not a small factor in deciding on this medium.

Objectives of the film production were to:

- present a realistic concept of the role of the student nurse;
- illustrate pictorially the activities and environment of a student nurse;
- promote a deeper understanding of the school by introducing ourselves to others;
- provide an interesting and meaningful audiovisual aid for those recruiting nurses;
- gain knowledge of film production through experimentation.

The subject matter was divided into roughly 50 percent educational and 50 percent social scenes. Included in the educational scenes were three types of classroom situations – role playing, lecture, and anatomy lab; a consultation of a head nurse and staff doctor with students at a busy nursing station; students learning to dress for the operating room – which provided some more humorous moments; and the library resource center.

To show a lighter, social side of student life, shots were taken of residence "happenings" and a favorite athletic activity – skating.

Filming sessions were followed by numerous, question-filled meetings to decide on editing cuts, titles, and music background. The final job was the sound track. For this, records that seemed to fit the mood and objective of each scene were used. The tempo was kept mainly fast and gay, but there were some serious moments.

Not only were students involved in the film, but patients also enjoyed participating by painting the background for the credits and title. – Marilynne Seguin, Reg. N., librarian and director/producer of *Where It's At,* St. Michael's School of Nursing, Toronto.

Orientation to Hospital Careers

Toronto General Hospital is taking part in a new high school work study program that gives grade 12 and 13 students an opportunity to spend two weeks in a hospital work setting where they can learn more about the realities of hospital careers.

The program was instigated by the North York Board of Education (Toronto) as a pilot project, and has proved to be a successful recruitment mechanism for nursing and allied professions.

On their first day in the hospital, students receive an orientation to facilities and to general behavior and ethics. Then they are assigned to departments such as nursing units, inhalation therapy, laboratories, and physiotherapy. Students work from 9:00 a.m. to 4:00 p.m. during the two week period.

Since the students work under the guidance of the volunteer department, additional responsibility is removed from the nursing staff. A volunteer smock with a student volunteer name pin identifies each student.

The nursing staff cooperates extremely well. Students who express interest in nursing are given the opportunity to observe procedures and to attend occasional lectures. They respond with eagerness and a willingness to learn.

About 85 percent of the students who share this experience make formal application for entrance into a nursing school or university to further a hospital career. Although all students find it a rewarding experience, some realize that a hospital career is not for them. – Mrs. Maureen Moody, Director of Volunteers, Toronto General Hospital. □



Student volunteer Sonja McKibbon (left) hears about the advantages of a pocket watch from third-year TGH student nurse Carol Goldman.



Mrs. Harlan Wilson, a Toronto General Hospital head nurse (left) shows student volunteers Phyllis Orton and Carol Wong how to make a hospital bed.



Come with me, Lori

Almost every nurse has experienced anxiety in her first contact with a psychiatric patient. This anxiety is normal and helpful. In this article, a student nurse examines her own feelings as well as her patient's feelings and tries to discover how these influenced both her own and her patient's behavior.

Lorraine E. Warwick and Jennie Wilting

What do I say or do to help a 44-year-old bachelor who has never had a stable home, steady job, or steady girlfriend, and who is now on a psychiatric ward with a diagnosis of schizophrenia? How do I meet and get to know a person who has little or no desire to live and little or no motivation or drive to try and regain a level of mental health so he can go back into the community?

I'm new here. I'm only a student. Why did they assign me to this patient? I don't know anything! How am I going to help a person like that? What will I say to him?

Getting acquainted

It was my second week on the psychiatric unit. I was assigned to a patient with whom I would be working during my entire psychiatric experience.

My patient, whom I will call Mr. Evans, was the oldest son in a family of six born to a farmer and his wife. His parents were Ukranian. Mr. Evans had a high school education. While obtaining this education, he lived alone in a cold, uncomfortable, discarded granary.

At age 20, he was admitted to a mental hospital and had been in and out of psychiatric hospitals and under psychiatric care ever since. Sometime during his life he learned the carpenter trade and built two houses. A brother lives in one of them. After being a patient at Alberta Hospital for five years, Mr. Evans was transferred to the psychiatric unit of the University of Alberta Hospital.

Mr. Evans looks his age: his hair is beginning to gray at the temples, he has a few forehead wrinkles, and his shoulders sag. He dresses in older styled clothes and the few that he owns were purchased at the Salvation Army. He is a quiet man, but not shy and looks directly at people when conversing with them.

Our personalities were so different. I am an active, fast-moving individual, who talks readily. When under stress or anxious, I tend to relieve my anxiety and tension by talking and increased activity. Mr. Evans, on the other hand, is an inactive, slow moving individual. He speaks slowly and uses short sentences. When under stress or anxious, he tends to relieve his anxiety and tension by silence and withdrawal. He didn't socialize in hospital and spent all his time in bed, unless someone specifically told him to go to some activity.

During the first week that I worked with Mr. Evans, I was anxious and lacked confidence in myself and in my ability to care for him. I looked to Mr. Evans for

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Miss Warwick is a third-year student in the four-year basic program leading to the degree of Bachelor of Science in Nursing at the University of Alberta. Her report on her ward experience in psychiatry was condensed into this article by Mrs. Jennie Wilting, an instructor on the staff at the University of Alberta.



reassurance – a nod, a smile, or an invitation to accompany him to certain activities – any sign whatever that would reassure me that I was doing well.

I am sure that some of my anxiety was communicated to Mr. Evans. However, with support and guidance from my team leader, my instructor, the patient's doctor, and other members of the health team, I gained self confidence and was able to look more objectively at my work.

A nursing care plan

Throughout the relationship, I noted and studied my feelings and behavior, as well as Mr. Evans' behavior. I tried to see how his behavior influenced my feelings and behavior and how mine affected his. As well, I wanted to see how my feelings influenced my observations and interpretations. When necessary, I tried to modify my behavior to meet the needs of Mr. Evans.

Space does not permit me to relate day by day interactions or progress, but, over the weeks and with the help of the health team, I formulated and carried out a nursing plan. My nursing plan included the following:

- establish a therapeutic nurse-patient relationship
- progress at the patient's pace
- gradually increase time spent together
- slowly direct conversation more and more toward his illness and problems
- tactfully increase his social and self-awareness
- learn about his past experience and his present behavior, feelings and thoughts
- observe his behavior in various areas of the hospital (dining room and recreational areas) and watch his reaction to different people (patients, doctors, and nurses)
- join him in planned activities (swimming, bowling, billiards, and discussion groups).

After working with Mr. Evans for five weeks, I tried to assess the progress we had made. I felt our relationship was growing steadily in trust and value as each day progressed. I was enjoying the challenge of working with him.

On looking back over the week's events, I noted that Mr. Evans had made many spontaneous contributions and indications of his trust and desire of our relationship. He showed me pictures of his niece; he showed concern for me and my time – "You have to get home" and "You'd better go" – which could be generalized to others eventually; he reached out and touched my shoulder, a very positive sign of friendship.

His appearance improved in that he bought some new clothes and shaved more often. The staff gently teased me about the fact that although Mr. Evans did not shave every day, he always shaved on the days I was scheduled to be on duty. He began to interact with the other patients and on one occasion invited a patient to join him in activities. He took a more active interest in his environment by commenting on various things going on around him.

Mr. Evans had developed a trust in me and he could share with me his thoughts and feelings about his niece, an old girl-friend, music, and past life. I felt rewarded that he revealed his trust in me. His mood had also improved. He was more spontaneous in conversation, happier, and more active.

Leaving the unit

Now we were ready to concentrate on formulating plans for Mr. Evans' return to the community, his living accommodations, and employment. It was very difficult for him to think about and plan his reentry into the community.

Several times his anxiety was so great that he could only cope with it by regressing; he would become withdrawn, non-communicative, and depressed. This I found very discouraging. However, as the days went by, his regression was less frequent.

Shortly after, when I had completed my psychiatric experience, Mr. Evans was discharged and went to live with his brother. He had been in the University of Alberta Hospital for seven months.

Now living with his brother, Mr. Evans is attending the day care program at the hospital. Under this program, he worked in the hospital's carpentry repair shop for eight weeks. Later, for more challenging work, he was transferred to the occupational therapy department. Here he has designed and made a coffee table and record holder, and is assisting with other articles, such as sewing machine cabinets. He seems to enjoy being a hard worker.

We both learned

I saw a great change in Mr. Evans during the 10 weeks that I worked with him. There was also a great change in me. No longer was I the frightened, insecure, unskilled student nurse of two months ago. I had lost my fear and gained self-confidence and skills in psychiatric nursing. I believe that both Mr. Evans and I benefited greatly from working together. □

research abstracts

The following are abstracts of studies selected from the Canadian Nurses' Association Repository Collection of Nursing Studies. Abstract manuscripts are prepared by the authors.

Saunders, Peggy, *A descriptive study of the behavior mothers exhibit, in response to each other during the early puerperium, in matters of family living with a newborn infant.* Montreal 1969. Thesis (M.Sc.N.(A)). McGill.

Based on the problem of preparedness of parents for family living with a newborn infant, the investigation describes how mothers respond to each other during the early puerperium in hospital. Two types of information were collected by means of observation and use of a check list. One was the frequency with which certain items of behavior were exhibited when two or more mothers responded to each other; the second was the frequency of different topic areas noted in conversations between mothers. Two hundred 10-minute observations were made of 96 mothers in hospital, varying in age, parity, and days postpartum. The results suggested that mothers respond to each other through conversing, smiling and watching. Also, that the behavior is continued by the majority of mothers beyond initial contact; and that some items of behavior vary significantly with age, parity, days post-partum, and the mother's country of birth. Findings indicate, too, that some topics of conversation occur more frequently than others, and vary with parity of the mother.

Kliewer, Pauline Annette. *Guilt: an operationally defined concept.* Seattle, Wash., 1969. Thesis (M.A.) U. of Washington.

Guilt is a factor that constantly influences both nursing performance and patient reaction, but has as yet been little researched in nursing. It was the purpose of this study to develop an operational definition of the concept of guilt.

The study was based on the observations made concerning guilt by five authors from psychiatry and five authors from the social sciences who specifically dealt with the problem of guilt. These observations were then tabulated according to the following categories: what guilt is, what causes guilt, how guilt is experienced, and what effects of guilt on behavior can be observed. This tabulation made it possible to trace the interrelationships of the various observations and delineate the general operations that make up the concept of guilt.

It was found that a person has certain standards and potentials; when these are violated he experiences a complex psycho-physiological reaction and begins to manifest various behaviors to cope with the experience of guilt. This researcher believes that this information about guilt can help nurses understand the dynamics of guilt and consequently deal with their own and patient guilt more effectively.

Wilson, Phyllis Margaret. *A guide for the public health nurse to assist elderly patients in the achievement of selected functional tasks at home.* Seattle, Wash. 1967. Thesis (M.N.) U. of Washington.

Occupying a key position in the increasing number of home care programs, the public health nurse has an important responsibility in giving nursing care and coordinating allied professional and volunteer services to promote independence of the elderly at home. The purpose of the study was to develop a guide that could be used by the public health nurse to assist elderly patients in the achievement of selected functional tasks at home.

The guide was designed by the writer to include five areas of daily living: mobility, self-care, food habits, household tasks, and pyschosocial adjustment. For each of these areas five functional tasks important in maintaining independence at home were selected, and aids to achievement were suggested for each functional task.

Employing the developmental method of research, 55 public health nurses in 9 British Columbia Health Units each used the guide with a patient who was 65 years or over, lived in a house or apartment, and had acute or chronic illness or changes associated with aging. Evaluation of the guide was made by the public health nurses' completion of the questionnaires and by the writer's observations of the used guides.

As a result of the findings the guide was revised with relatively minor alterations to the format and content. Analysis of the data was also helpful in confirming that the guide would be helpful in determining the patient's suitability for home care, developing a nursing care plan to focus on the patient's individual and total needs in relation to achieving maximum independence, facilitating liaison with family and allied personnel, and providing on-going evaluation of patient progress. In addition, recommendations have been made in relation to further development of the guide and its extended use in other phases of geriatric care.

Wallington, Marjorie A. *An approach to the phases of nurse-patient relationships.* Boston, 1968. Thesis (M.Sc.N.) Boston U.

This is a library study designed to examine the development of trust as the first phase of a nurse-patient relationship. The assumption was made that when a patient enters into a relationship with a nurse, this relationship will follow an orderly pattern that can be described in terms of its phases. A second assumption was made that the orderly pattern followed in a nurse-patient relationship is a re-enactment of the phases of child development. The child development stages listed by Erikson were used as a proposed pattern for the phases of a relationship.

The study dealt with one aspect of phase 1 – *trust.* Trust was examined as it exists in a nurse-patient relationship: its meaning, how it is developed, factors that inhibit and foster trust, and how trust is demonstrated.

According to the definition of trust presented in this study, three criteria must be met before trust exists for the patient in a relationship: 1. The patient must recognize and understand the limits which are set for his behavior. 2. The patient must be assured of his own ability to function within these limits. 3. The patient must receive reciprocal trust from the nurse.

A review of literature supported this definition in principle, although the word "limits" is rarely used in this context.

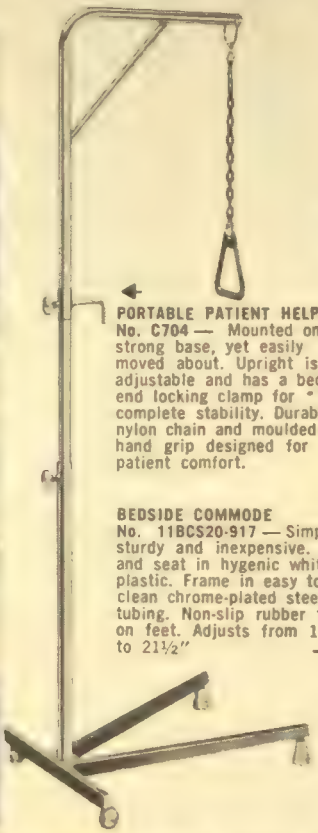
A suggested list of behaviors that may demonstrate trust was presented. Recommendations included: 1. The suggested list of behaviors that demonstrate trust should be tested in the clinical setting to refine, add to, and test for reliability and

(Continued on page 52)

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research abstracts

(Continued from page 50)

validity. 2. Similar additional studies should be made to examine the other phases in the proposed orderly pattern of the nurse-patient relationship. 3. When the other phases in the proposed orderly pattern have been examined and defined in the context of the nurse-patient relationship, the total pattern should be examined and tested in the clinical setting to ascertain if the pattern does exist and if it can be measured.

Hayward, Margaret. *Correlates of approval and disapproval received by students at selected schools of nursing.* Pittsburg, Pa., 1969. Thesis (Ph.D.). U. of Pittsburg.

The basis for this study was the concern many have expressed for the nurse's gradual move from giving patient care to becoming involved with administrative duties. Its purpose was to find if the student nurse was influenced toward moving in this direction through approval and disapproval received by her for her nursing behavior. These responses were considered to be one informal method of teaching which, according to reinforcement theory, was one way one individual influences the behavior of another. This study attempted to describe the kinds of behavior for which students remembered receiving these responses and to find the percent of approval and disapproval they received. It attempted to find if either of these variables correlated significantly with the needs of the students, with the persons from whom they received most of their responses, or with the type of nursing school in which they were enrolled. Finally, the study sought to determine if the behavior it found was being impressed on the students through this informal method were supporting or negating the educational objectives of the schools.

Two hundred and twenty-seven beginning students from two university-related and two hospital-related schools participated in this study. They submitted over 5,000 incidents through use of the critical incident technique, each of which told of a nursing behavior for which they had been given approval or disapproval. When categorized, these incidents fell into 15 minor categories which in turn were grouped into three major categories called "giving care to patients," "working with others," and "grades and classroom activity." When the percent of incidents submitted by each student in each of these categories and the percent submitted by them of approval and disapproval was correlated with their needs as described by their scores of the EPPS, and with the percent of incidents they received from patients, instructors, and ward staff, few correlations of significance were found. The schools in which they were enrolled failed also to correlate with significance to these variables.

The Pearson r, Tetrachoric r and Intraclass correlation were the statistical methods used. A rating scale was created for use in this study but was dropped from inclusion in it because of time being insufficient for adequate testing. Its purpose was to have been to contribute another dimension by describing the students skills in nursing, as seen by her instructor. In each school these beginning students reported their largest percent of incidents as having been received for "giving patient care." Since each of their schools stated that one objective was to teach students to give a high level of patient care, these data suggest that this informal means of teaching was being used in these four schools to support this objective.

Although many minor recommendations were made in conclusion to this study, the dominant recommendation made was that the critical incident technique, used so effectively in a slightly revised form in this study, be used again as a way of studying the process of education as it is experienced by the student.

Trout, Margaret F. *Criteria used by employers when selecting nursing staff in varying sized hospitals.* Toronto, 1964. Thesis (H. Admin.) Univ. of Toronto.

The rapid changes in the health field during and since World War II have created many problems for those responsible for supplying needed services. Population increases, economic expansion, and the changing values of society have increased demands for more and improved health and welfare services in all countries. Traditional staffing patterns of health agencies had to be drastically altered to cope with severe shortages of personnel and expanding facilities. Educational methods had to be modified also and new approaches used to keep up with the advances in all technical and organizational fields.

The hospital, staffed traditionally by "the learn as you serve method," found itself hard pressed to compete with other more attractive and lucrative vocations. The staffing pattern, set by Florence Nightingale, consisted in the main of graduate and student nurses assuming all duties relative to patient care, with a preponderance of students in hospitals that operate schools of nursing. During the war, shortages of both student and graduate nurses first necessitated the introduction of unskilled or partially trained workers into the nursing hierarchy The role of the graduate nurse changed appreciably – widening in scope and with the emphasis shifting from direct patient care activities to managerial and supervisory functions. Breaking with traditional ideology is always painful and the confusion that naturally ensued within the profession itself was compounded by the interposition of changing ideas from other and allied fields.

With needs pressing, the role of the graduate nurse became of great moment. Employers were faced with the problem of utilizing these key people to best advantage while being bombarded by demands from the public, demands from the medical profession, and demands from the nursing profession, all of whom regarded the nurse in the light of their own needs and preconceived images.

This study endeavors to ascertain some of the basic criteria upon which employers select graduate nurse staff. Because of the ramifications that relate to the topic, it is limited in scope. Only graduate nurse staff in general hospitals have been considered and no breakdown has been attempted between teaching and non-teaching hospitals.

The balance between nursing service and nursing education has not yet been struck. Much clarification and interpretation on both sides is needed and a further study of the correlation between preparation and function would be of great value in promoting understanding and a closer working relationship between these two groups. It would require, however, quite extensive research and was beyond the scope of this paper.

This study, therefore, is confined to establishing basic criteria presently used by employers when hiring nursing personnel and comparing differences, if any, in hospitals of varying size. Any conclusions drawn can only be applied within the framework of a changing picture, as the factors contributing to the formation of the opinions on which these conclusions are based are still in a state of flux.

Kergin, Dorothy J. *An exploratory study of the professionalization of Registered Nurses in Ontario and the implications for the support of change in basic nursing educational programs.* Ann Arbor, Michigan, 1968. Thesis (Ph.D.) U. of Michigan.

The Canadian Nurses' Association has published statements regarding basic nursing education that designate two categories of nurses, one prepared in a baccalaureate degree program and the other in a two-year diploma program. The ob-

research abstracts

jective of this study was to determine what discrepancies in professional attributes there were among Ontario nurses that might affect their acceptance of the proposed changes in basic nursing education.

The survey approach was selected as the research method and a questionnaire was mailed to a probability sample of female nurses, registered in Ontario in 1967. To insure that comparisons could be made by educational groups, a variable sampling fraction was utilized for each of three strata, consisting of nurses with 1. no academic degress, 2. baccalaureate degrees, and 3. graduate degrees. Questionnaire returns totaled 549, or 76 percent. The chi-square statistic was used for computer analysis of the data, supplemented by t tests of the differences between uncorrelated means

Following a review of literature, 12 attributes of the highly professionalized nurse were stated. These attributes were related to a nurse's beliefs and attitudes concerning professional nurses' associations, professional education, and professional status, and were employed as an attitude universe of professionalism. Believed to be associated with these 12 characteristics were certain behavioral outcomes, among them selected scholarly activities and knowledge of the statements of the CNA on nursing education and the association's adoption of the Code of Ethics of the International Council of Nurses as the code for Canadian nurses. Education, age, and professional association membership were identified as three antecedent variables, associated with professionalism in nurses, and constituted the independent variables for the analysis of the data.

For all except the final attribute, related to satisfaction with career choice, the general statement can be made that, for Ontario nurses, as their level of education increases, so does their level of professionalization. The findings indicate disparities in levels of professionalization, particularly between respondents with graduate degrees and those with little or no university preparation, that is, between many present and future leaders of the profession and its rank-and-file members.

Among these disparities are differences in attitudes and beliefs related to the responsibilities of the professional nurses' associations with respect to future nursing education, perceptions of nursing's public service obligation, attitudes toward new graduates of basic baccalaureate and two-year diploma programs, and recognition of the research potential of a nursing problem. Most relationships that were apparently attributable to age or association membership may have been biased by a spurious relationship to education. The finding that as a nurse's age increases, so does the tendency for her to belong to a professional nurses' association, illustrates a deferred occupational commitment that is more typical of women than of men.

Based on the findings, the major conclusions and recommendations are directed toward the achievement of an informed and supportive nurse population with respect to educational change. One of the recommendations is that committees be established at the chapter level of the provincial nurses' associations, to lead discussions within the chapters of current issues in nursing, including the need for educational reform. It is suggested that the profession's obligation to serve the public interest with respect to expert nursing care provide the rationale behind these discussions. To clarify the nursing profession's public service obligation further, it is also suggested that the CNA, in conjunction with its provincial constituents, initiate discussions of a Canadian code of ethics for nurses. □

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Basic Microbiology, 2nd ed. by Margaret F. Wheeler and Wesley A. Volk. 410 pages. Toronto, J.B. Lippincott Company, 1969.
Reviewed by Moira L. O'Brien, Science Instructor, St. Martha's Hospital, Antigonish, N.S.

A good reason for choosing this text for a diploma program is its easy, conversational approach to the material covered. It covers the material well, but avoids unnecessarily deep language.

The second edition of this useful text is larger, and includes the latest scientific developments in microbial genetics, cell structure, and immunology. DNA synthesis, RNA synthesis, and protein synthesis are presented in a clear and attractive manner. More diagrams and illustrations have been added to explain difficult points.

In short, the book is excellent for a diploma program.

Social Work In The Hospital Organization by Margaret Gaughan Brock. 117 pages. Toronto, University of Toronto Press, 1969.
Reviewed by Mrs. N. Nera, Director of Social Services, Ottawa Civic Hospital, Ottawa, Ont.

Readers will find this book straightforward and comprehensive. It attempts to define and describe social work within the hospital setting and within the broader context of health care. It is informative and historical.

The author's attempt to make it comprehensive may make it somewhat dull for many experienced social workers. However, as the author points out, it should serve as a basic text for such groups as social work students, hospital board members, hospital administrators, nursing students, and especially for social workers in the community and primary agencies not too familiar with the hospital machinery.

The chapter on the role of the social worker in the hospital is thorough. The chapter discusses consultation and collaboration as two important functions, but makes it obvious that the primary function is service to patients and their families. Formal and informal teaching are also discussed; definitions are handled clearly.

Chapters six and seven bring in the "ingredients" of social work administration in a way that would be useful to beginning administrators. The author shares her years of experience, and manages to mix learning and practice in an interesting manner. She fails to mention, however, anything about the costs of social work service in a hospital, although she deals with costs of social work recording.

In chapter eight, the author illustrates various situations where social work interventions in a hospital setting have helped in total patient care. She is also able to illustrate efforts that have failed.

The author finishes the book with a discussion of social work as the "third dimension." She explains that "illness has many forms and undoubtably many meanings. How the patient perceives his illness can often only be understood in relation to his culture, social class, religion . . . " The author has done an excellent job on this text. Any succeeding texts perhaps could deal with the changing role of the social worker in hospitals.

Anatomy of the Newborn: An Atlas Edmund S. Crelin, 256 pages. Philadelphia, Lea & Febiger, 1969. Canadian agent: Macmillan Co. of Canada Ltd., Toronto.
Reviewed by Glennis Zilm, formerly assistant editor of The Canadian Nurse.

The author, a professor of anatomy at Yale University School of Medicine, prepared this atlas because he was disturbed about the lack of suitable texts on anatomy of the newborn. In the preface to this book, he points out that descriptions of newborn anatomy are limited to scattered passages in adult anatomy and surgical texts.

The need for a specialized work on this subject is best stated in the author's introductory words: "The newborn is not a miniature adult. Some of the differences between a structure of the newborn and that of an adult are quite complex. For example, the overall size of the adult temporal bone is about twice that of the newborn temporal bone. However, in the temporal bone of the newborn the diameter of the internal acoustic meatus, the size of the inner and middle ear cavities, the fenestra vestibuli, the fenestra cochleae, the malleus, incus, and stapes, and the tympanic membrane, or eardrum, equal the size of these same structures in the adult temporal bone."

As might be gathered from the above, this is not primarily a book for nurses; it is, however, the kind of primary essential reference that should be available in any pediatric surgical department.

The atlas is comprised of 296 labeled drawings prepared by the author. He based the drawings on findings on dissection of newborn cadavers. The drawings are shown in proportionate sizes to a mean body size and shape representing the average newborn of about nine months gestation. Because the author did all the dissection and all the drawings, he was able to achieve a continuity of illustration not usually found in an anatomical atlas.

The book is atlas-size (12-1/4" x 10-1/4"), beautifully printed and bound, and well-indexed. It is also expensive, but seems well worth the price.

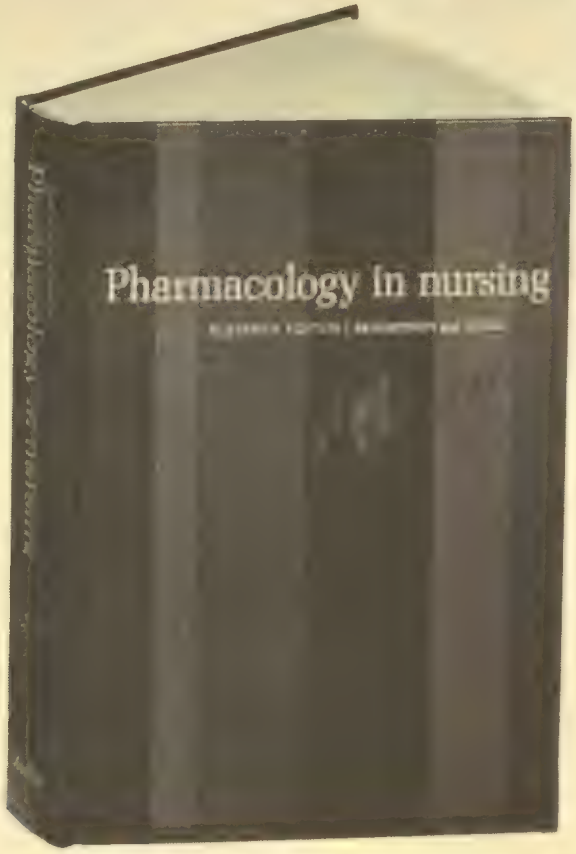
Psychosocial Nursing, edited by Elizabeth Barnes. 316 pages. London, Eng., Tavistock Publications, 1968. Canadian Agent: Methuen Publishers, Toronto.
Reviewed by Barbara Hazlewood, Credit Valley School of Nursing faculty, Mississauga, Ontario.

This collection of papers, written between 1946 and 1967, offers an account of the approach to the treatment of psychiatric patients and the training of psychiatric nurses developed at the Cassel hospital in England.

The approach presented is based on three concepts. First, the hospital is a therapeutic institution within which the patient is responsible to himself for himself. Second, all aspects of psychiatric nursing are built on a foundation of psychoanalytic principles. Third, the psychiatric nurse is trained to see herself and her patient as an individual who remains a part of his family and community.

The papers are arranged in five sections. Part one discusses the development of the hospital as a therapeutic institution. The third paper in this section outlines the present methods employed in the training of psychiatric nurses and serves as a guide to the Cassel philosophy of psychosocial nursing.

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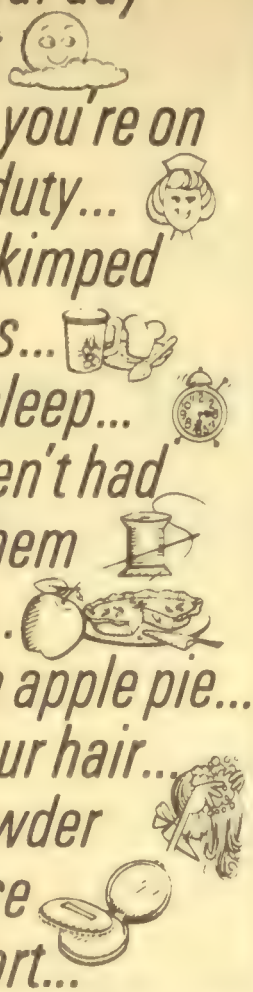
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(Continued from page 54)

The first two papers of part two describe how the staff came to realize that the "mothering techniques" of nursing were doomed to fail with the emotionally disturbed and how this realization led to a reclassification of the nurses' role. The remaining five papers discuss the resulting experiences of the nursing personnel.

To maintain the patient's contact with his family, a program emphasizing family involvement was developed. The papers in part three are concerned with such issues as children remaining with their mothers, the involvement of all members of the family with problems of the adolescent patient, and visits by the nurse to the patient's home before, during, and after hospitalization.

Part four enlarges on the second of the three major concepts. Psychoanalytic techniques are utilized in the process of selecting and educating psychiatric nurses for their role as therapeutic agents. The final part consists of a summary of the changes that have evolved at the Cassel hospital during the last two decades.

This book would not be useful as a text. However, it is of value to the student nurse examining the role of the social sciences within her profession, and to the graduate nurse involved in the care of emotionally disturbed patients. All three major concepts should be applied to the nursing profession at large.

Bedside Nursing Techniques in Medicine and Surgery, 2nd ed. by Audrey Latshaw Sutton. 398 pages. Toronto, W.B. Saunders Co. of Canada Ltd., 1969.
Reviewed by Mrs. Mary Carr, Instructor, Nursing Assistant Program, South Peel Hospital, Mississauga, Ont.

This "handbook of practical reference for the bedside nurse" is divided into two sections. The first section is concerned with general nursing techniques, which include planning bedside nursing care, hypothermia, radiotherapy, administration of oxygen, and the use of respirators.

The second section is divided into chapters on diseases of the body systems. Each chapter includes a description of diagnostic tests, preparation of the patient for them, and the normal results of the tests. Therapeutic and rehabilitative procedures, such as types of suction and drainage, stump dressings, care of casts, and how to use equipment like the CircOlectric bed, are also discussed. At the end of each chapter is a list of additional procedures, diets, and medications.

The author states that "although this book is procedure-centred, nursing is certainly not." The procedures are presented clearly, and in a logical sequence. The detailed illustrations are invaluable. The nursing care of a patient undergoing the various tests and procedures is briefly but adequately described.

The book contains a wealth of information and is an excellent reference book. It would be helpful to teachers and students of nursing, to a hospital procedure committee setting up new procedures or revising old ones, and to nurses returning to nursing practice after some time away from it. It would be a valuable addition to any nursing library. The only drawback to its regular use by staff on a nursing unit would be the small discrepancies between the textbook and the employing agency's own policies and procedures.

Basic Physiology and Anatomy, 2nd ed., by Ellen E. Chaffee and Esther M. Greisheimer. 634 pages, Toronto, J.B. Lippincott Company, 1969.
Reviewed by Mrs. Robin Gardner, medical-surgical instructor, School of Nursing, Women's College Hospital, Toronto.

The study of physiology and anatomy is basic to our understanding of the body in health and disease. Knowledge in this field is rapidly increasing. This revised edition has been expanded and updated to include new scientific knowledge. It presents anatomy according to the various systems of the body, and is "devoted primarily to gross anatomy." Physiology is studied in more detail than in most anatomy and physiology books for nurses.

The introductory chapter provides a basis in descriptive terminology. The second chapter is exceptionally good. It discusses the organization of the living body within the following framework: the organization of the cell, cell division, protein synthesis, maintaining homeostasis, the primary tissues, tissues as building materials, and an introduction to the systems. The many illustrations clarify subjects from the structure of DNA to the carrier system theory for the active transport of sodium and potassium.

The remainder of the book is organized by systems. The section dealing with the nervous system is good, with detailed explanations accompanied by diagrams to aid the student. In the section on the brain, cerebral lesions are related to symptoms a patient would present. The cardiovascular system is also explained well, with much attention given to the electrical activity of the heart and the electrocardiogram.

Each section relates the study of anatomy and physiology to nursing. For instance, in the study of the skin the blood supply is related to the development of decubitus ulcers; and in the chapter on the kidneys, hemodialysis is explained. Although this is not a text on medical-surgical nursing, it does contain enough of these "extras" to whet the appetite of the beginning student.

There are several teaching aids. At the end of each chapter, there is a summary that defines and summarizes the contents in concise terms, and a list of practical questions pertaining to nursing which would stimulate the student nurse and remind her why she is studying anatomy and physiology. A glossary and a small bibliography are also included. There is an insert of transparencies illustrating the depth of the organs and systems in the human body.

This text would be useful as a textbook for the student nurse, or as a reference book for the instructor or graduate nurse.

An Introduction to the Physical Aspects of Nursing Science by O.F.G. Kilgour. 292 pages. London, William Heinemann Medical Books Ltd., 1969. Canadian agent: Burns & MacEachern Ltd., Don Mills, Ont.

Reviewed by Jean Godard, Assistant Professor of Nursing, McGill University School for Graduate Nurses, Montreal, Que.

In this well-illustrated text, the author has attempted to present in relatively simple terms the areas of physics that have special significance for nurses. He begins with the study of measurement and proceeds through 12 chapters on such topics as dialysis, forces and machines, pressures, heat, light, and electricity. There is sound and up-to-date material on the laser, cryosurgery, ultrasonics, gamma cameras, and the effects of gravity on astronauts.

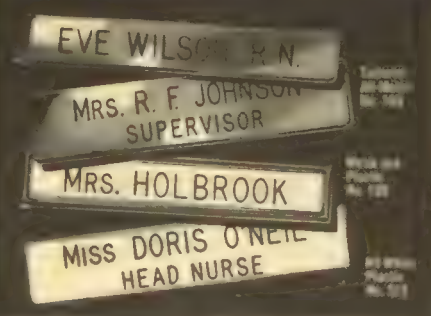
Frequent definitions are included and experiments accompany each section. There is a list of visual aids at the end; however, these are largely obtainable from Great Britain and may prove difficult to locate for Canadian instructors.

There is a need for this kind of text, and although I might hesitate to have some nurses follow the instructions on "how to wire a 3-pin standard plug," nonetheless it is particularly well written.

This book would be a valuable reference source for the beginning student who is being initiated into the mysteries of physics in nursing, for the instructor who might spend hours organizing laboratory sessions, and for the majority of students and graduates in the health professions. The reader will also find it a source of enjoyment.

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Tara Dier, Ottawa, p. 9

Julien LeBourdais, Toronto, pp. 10, 31, 32, 34, 39

St. Michael's School of Nursing, Toronto, p. 46

The Globe and Mail, Toronto, p. 47

books

Microbiology in Health and Disease, 12th ed. by Martin Frobisher, Lucille Sommermeyer, and Robert Fuerst. 549 pages. Toronto, W.B. Saunders Company, 1969.
Reviewed by Sharon Chambers, Faculty, Royal Victoria Regional School of Nursing, Barrie, Ont.

The twelfth edition of this text has kept pace with the changes in the education of health personnel. It is no longer specifically for the nursing field, but has been revised so that it can be used as an introduction to microbiology for all branches of the health services.

The text is divided into five sections with appendices. Each of the first four sections is made up of four to six chapters. Section one discusses the characteristics of the various types of microorganisms (viruses and bacteria are individually covered in separate chapters). Section two deals with microorganisms in their environment, methods of laboratory study and their usefulness in sanitation, industry, etc. Section three concerns principles of destroying microorganisms and outlines the various methods most commonly used. Infection, immunity (active and passive) and allergy are the topics of section four.

The last 20 chapters make up the fifth section on pathogenic microorganisms, which is divided into six parts. Five of these concern various diseases, divided according to the system through which the pathogen is transmitted. The sixth, which consists of the final chapter, outlines the responsibilities of health personnel in relation to transmissible diseases.

The above is a birds-eye view of the contents of this text which may help you compare the relative merits of this text with others on the same topic. Those who know the previous edition will find similar content with some additions and deletions.

The illustrations and tables reflect the authors' objective of removing obsolete material and substituting it with updated facts.

Because the authors have removed the nursing orientation, this text's main advantage is its versatility. It is organized so that a chapter (or a part of one) can be read even if the reader has not covered the preceding chapters. Public health nurses, registered nurses, and health and nursing educators can use this text as a valuable reference to meet their specific needs in this field.

Schools of nursing are looking for integrated texts to include all the sciences, thus the usefulness of this text for nursing students is limited. This book could and will continue to be used as a library reference to which students could be referred. It also might be of some use in assisting high school students to choose a field related to the specific study of microorganisms.

Screening for Health; Theory and Practice by H.P. Ferrer. 212 pages. Toronto, Butterworth & Co. (Canada) Ltd., 1968.
Reviewed by Sister Mary Irene, Director, Prince Edward Island School of Nursing, Charlottetown, P.E.I.

In the foreword to this book, the medical officer of health for the city of Liverpool states that when the community health field is undergoing considerable change, a collection of knowledge on screening for health provides a source of useful information of general and technical nature. This book attempts to serve that purpose.

The book is written for the British National Health Service, and the facts compiled on screening tests pertain almost solely to England. Some comparative data on incidence of disease in other countries is included, however. It is extremely well documented with references, and contains 89 tables that are highly informative.

A chapter on screening is devoted to each of the following areas: infancy and childhood; tuberculosis; anemia; diabetes; cancer; bacteriuria; miscellaneous screening for glaucoma, mental health, hypertension, chronic bronchitis, and coronary artery disease. A chapter on future patterns of health screening for the promotion of health expresses a view worth consideration. There are five appendices on various diagnostic aids used as screening procedures.

The book is factual and would make a good reference, although its use as a student's reference would be limited.

A Textbook for nursing assistants, 2nd ed. by Gertrude D. Cherescavich, 439 pages. Saint Louis, Mosby, 1968.
Reviewed by M.A. Felix, Department Head, Practical Nurse Training, Manitoba Institute of Technology, Winnipeg, Manitoba.

In the preface, the author mentions that this textbook is written for the many non-professional workers in the nursing team who are employed to assist in giving nursing care. It would also be useful, however, as a guide for the professional nurse who is instructing nursing assistants, nurses' aides, practical nurses, and orderlies in hospitals or in approved schools.

The author stresses the principles involved in nursing procedures and in-

dicates how the patient's needs can be met with greater understanding and efficiency by a nursing assistant who knows and applies these principles in giving nursing care. The nursing assistant is helped to identify her own role in nursing care and to understand the effects of physical and emotional illness on her patients.

The text is divided into four sections. An introduction gives a brief outline of types of hospitals, team nursing, and the role of the nursing assistant in the team. The lack of conformity in the nursing assistant's role from hospital to hospital is mentioned. The second section is concerned with meeting the patients' basic needs: a comfortable bed, food and water, cleanliness, movement, sleep, and elimination. The procedures given in relation to these needs are comprehensive and detailed, with the patient as the focal point around which the team operates. Some anatomy and physiology is included, although the text is mainly concerned with nursing care. The material is well presented, with the procedures explicitly explained in point form. The headings for the procedures and relevant information are frequent and descriptive. Numerous diagrams and illustrations should help the student in identifying various disease conditions and in giving specific treatments. The administration of medications is not included in the text.

The third section deals with the particular needs of the patient. This section covers a number of procedures that many non-professional nurses can be taught: admission and discharge of patients, vital signs, collecting specimens, enemas, colostomy care, and catheter irrigations. In this section also, principles are given and stressed. The needs of special patients include caring for a patient with a communicable disease, caring for an emotionally ill patient, preoperative and postoperative care, and caring for the breathless patient.

The fourth section deals with the needs of the special patient. The material in this section is informative; however, a few of the procedures would not likely be the responsibility of the nursing assistant or the practical nurse, such as throat suctioning in postoperative care.

The vocabulary is not too technical and the meanings of medical terms are given at the end of each chapter. Summaries and review questions are also included at the end of each chapter.

This text could be of great value to both the student and instructor in outlining modern accepted methods of patient-centered care and the principles involved in this care.

Forces Affecting Nursing Practice edited by Dorothy D. Petrowski and Margaret T. Partheymuller. 117 pages. Washington, D.C., The Catholic University of America Press, 1969.

Reviewed by Ruby Cuthbert, Regional Supervisor, Victorian Order of Nurses, National Office, Ottawa, Ont.

Each spring the school of nursing of The Catholic University of America has sponsored a continuing education series. These papers, given by members of the faculty of the school of nursing, the University of America, a local Visiting Nurse Association, and a member of the public health service, have been compiled into book form.

Each lecture or chapter shows how the nurse of the future will need to be educated, not only in nursing procedures, but also in the technological field. This need will present a difficult task for educational institutions. As the lecturer dealing with automation points out, "The nurse will need to be able to describe what she does — the computer is only as good as the thought processes used to plan it."

These lectures must have been fascinating to listen to, and to discuss with the lecturers. A few of the lectures need the personality of the lecturer, but not all.

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Stamps to cover payment of postage from library to borrower should be included when material is returned to CNA library.

Books and Documents

1. *AHA nursing activity study; project report* Chicago, American Hospital Association, 1968. 83p.

2. *Anatomy of the newborn: an atlas* by Edmund S. Crelin. Philadelphia, Lea & Febiger, 1969. 256p. R

3. *Basic pharmacology for nurses,* 4th ed. by Jessie E. Squire. Saint Louis, Mo. Mosby, 1969. 329p.

4. *Basic physiology and anatomy* by Ellen E. Chaffee and Esther M. Greisheimer, 2d ed. Philadelphia, Lippincott, c1969. 634p.

5. *A brief history of pharmacy in Canada.* Toronto, Canadian Pharmaceutical Association, 1967. 113p.

6. *Cancer ward* by Alexander Solzhenitsyn. Translated from Russian by Nicholas Bethell and David Burg. New York, N.Y., Bantam, c1969. 559p.

7. *Crisis at Columbia;* report of the Fact-Finding Commission appointed to investigate the disturbances at Columbia University in April and May 1968. New York, Vintage Books, c1968. 222p.

8. *Diplomacy in evolution;* report of the Canadian Institute on Public Affairs 30th Couchiching Conference, 1961 edited by D.L.B. Hamlin. Toronto, University of Toronto Press for Canadian Institute on Public Affairs, c1961. 128p.

9. *Dossier homosexualité* par Dominique Dallayrac. Paris, Laffont, 1968. 514p.

10. *Essentials of nursing: a medical-surgical text for practical nurses,* 2d ed. by Claire Brockman Keane. Philadelphia, Saunders, c1969. 491p.

11. *History, School of Nursing, Toronto General Hospital, Volume 2, 1932-1967* by Mary E. MacFarland. Toronto, 1968. 60p. R

12. *Index of Canadian Nursing Studies* compiled by CNA Library, Ottawa, Canadian Nurses' Association, 1969. R

13. *La loi et la maladie mentale;* rapport du Comité d'études sur la Loi et la Maladie Mentale du Comité scientifique national de Planification. Montreal, L'Association canadienne pour la Santé mentale, 1969. 3v.

14. *Management techniques for the hospital executive housekeeper* by the National Sanitary Supply Association and Executive Housekeepers of America. Chicago, 1965. 72p.

15. *A manual for team nursing* developed by Mercy Hospital, Pittsburgh, Penn. St. Louis, Mo., Catholic Hospital Association, c1968. 56p.

16. *Manual of hospital housekeeping.* Chicago, American Hospital Association, 1959, 113p.

17. *Medlars 1963-1967* by Charles J. Austin. Washington, U.S. Dept. of Health, Education, and Welfare, 1968. 76p.

18. *Mental hospitals join the community,* New York, Milbank Memorial Fund, 1964. 180p. (Milbank Memorial Quarterly, v.42, no.3 July 1964, pt.2)

19. *Nurse participation in hospital product selection: verbatim descriptions of the nurse's role in supply and equipment selection.* New York, American Journal of Nursing. Advertising Research Department, 1967. 4v.

20. *Nursing in respiratory diseases; a symposium* edited by Mary G. Helming. Philadelphia, Saunders, reprinted from Nursing Clinics of North America, Sep. 1968 for National Tuberculosis and Respiratory Disease Association, 1968. p.381-487.

21. *Nursing trends; a book of readings* by M. Virginia Dryden. Dubuque, Iowa. Brown, c1968. 327p.

22. *Répertoire, 1969 des études et travaux rédigés au Canada au portant sur des sujets louchant le domaine infirmier au Canada* compileé par les soins de la bibliothèque de l'AIC. Ottawa, Association des infirmières Canadiennes, 1969. 2v. R

23. *Report of the Nursing Conference on the Care of Patients with Cardiac Involvement,* Inn on the Park, Toronto, May 13-17,1968. Co-sponsored by Ontario Heart Foundation, Ontario Hospital Association, Ontario Medical Association, Registered Nurses' Association of Ontario. Toronto, Registered Nurses Association of Ontario, 1969. 132p.

24. *Soins infirmiers; précautions à prendre;* élaborés avec la collaboration de plusieurs groupes de monitrices et de Mme Got ex-directrice de l'Ecole d'infirmières de l'Hôpital Saint Antoine, à Paris. Paris, Lamarre-Poinat, 1968. 225p.

25. *Survey report on the wastage of general trained nurses from nursing in Australia, Nov. 1960-Nov. 1967,* by Royal Australian Nursing Federation, National Nursing Education Division and the National Florence Nightingale

Committee of Australia. Victoria, 1967. 1v. (various pagings)

26. *Syntaxe du français moderne, ses fondements historiques et psychologiques* par Georges LeBidois et Robert LeBidois. 2d ed. Paris, Auguste Picard, 1968. 2v.

27. *Textbook of pediatric nursing*, 3d ed. by Dorothy R. Marlow. Philadelphia, Saunders, c1969. 687p.

28. *Workbook in bedside nursing maternity nursing* by Inge J. Bleier, Philadelphia, Saunders, c1969. 147p.

Pamphlets

29. *Les cinquante premières années; une esquisse d'histoire.* Ottawa, Association des Infirmières Canadiennes, 1959? 17p.

30. *History of the nurses official directory of the Registered Nurses Association of Nova Scotia, Halifax Branch* by Anna (Robert) Thorpe. Halifax, 1967. 7p. R

31. *How to attend a conference* by S. I. Hayakawa. San Francisco, International Society for General Semantics, 1969. 7p.

32. *Nursing in Sweden* prepared by Swedish Nurses' Association, Stockholm; The Swedish Institute, 1965. 8p.

33. *Schoolgirls' interest in nursing as a career* by Robert Gillan. Kensington, N.S.W., School of Hospital Administration, University of New South Wales, 1968. 38p.

34. *Swedish Nurses' Association*, Stockholm, 1969. 83p.

35. *Social and economic welfare goals - 1970;* approved by Board of Directors, February 1969. Ottawa, Canadian Nurses' Association, 1969. 4p.

Government Documents

Canada

36. Dept. of National Health and Welfare. *Careers in Canadian medicine* by . . . in co-operation with the Canadian Medical Association. Ottawa, 1969? 1v.

37. ———. Dental Health Division. *Dental Health manual.* Ottawa, Queen's Printer, 1969. 46p.

38. ———. Health Insurance and Resources Branch. Health Grants Directorate. *National health grant manual, April 1, 1969.* Ottawa, 1969. 6p.

39. Ministère de la Santé nationale et du Bien-être Social. Services de Santé d'urgence. *Plan de l'evacuation des hôpitaux.* Ottawa, L'Imprimeur de la Reine, 1960. 55p.

40. ———. Services de Santé nationale et du Bien-être social. *Plan hospitalier en cas de sinistre.* Ottawa, L'Imprimeur de la Reine, 1959. 33p.

41. ———. *Projets de recherche et études dans le domaine hospitalier, 1967.* Ottawa, 1968. 121p.

42. National Library of Canada. *Canadian theses 1966/67.* Ottawa, Queen's Printer, 1969. 234p.

43. National Research Council of Canada. *Report of the president, 1967-1968.* Ottawa, 1969. 126p.

44. Science Council of Canada. *The role of the federal government in support of research in Canadian Universities* by John B. Macdonald and the Canada Council with a minority report by L.P. Dugal. Ottawa, Queen's Printer, c1969. 361p.

Quebec

45. Ministère de l'Industrie et du Commerce. Bureau de la Statistique du Quebec. *Taux de salaire et heures de travail, October 1967.* Quebec, 1968. 1v.

46. ———. Centre d'information Statistique. *Annuaire du Quebec, Québec yearbook, 1968-69.* Québec, Editeur official du Quebec, 1969. 840p.

Studies Deposited in CNA Repository Collection

47. *A descriptive study of the behavior mothers exhibit in response to each other during the early puerperium, in matters of family living with a newborn infant* by Peggy Saunders. Montreal, 1969. 42p. Thesis (M.Sc.(App)) - McGill. R

48. *Extended care and the general hospital* by R. K. McGeorge. Toronto, 1969. 120p. Thesis (Dip.H.A.) - Toronto. R

49. *La philosophie des soins organises a domicile* par Jean-Benoît Bunock. Ottawa, Ministère de la Santé Nationale et du Bien-être Sociale, 195? 31p. R

50. *The philosophy of organized home care* by Jean-Benoît Bunock. Ottawa, Dept. of National Health and Welfare, 195? 31p.R □

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The Canadian Nurse

A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 65, Number 10 October 1969

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"It would be entirely wrong for you to give an impression of flashy opulence, of course; but on the other hand you should be ware of [your premises] becoming an eyesore."

These words of advice are addressed to undertakers – that much maligned group whose services everyone tries to avoid – in an article in a British publication that asks: "How Can the Funeral Director Improve His Image? " *(Public Relations,* Augus 1969.) It seems that undertakers, as everyone else in the community, are anxious to be well regarded by the public. They are, however, faced with a difficult PR task, since they are often criticized unfairly for making a living out of others' grief, even though they are providing an essential service.

And funeral directors aren't the only ones who are trying to improve their image these days. Even the students are having a go at it. An article in the July issue of *Public Relations Journal* (U.S.A.) tells how a group of university students in Florid went to work to clean up their host community for its annual Beautification Week. The article was entitled, "Help to Town Builds Student Image." These students were apparently concerned about the negative image that a minority of radical students on campus were creating. They wanted to change the student image and thus improve campus-community relations, which were somewhat strained.

There is a temptation to be cynical about such efforts by groups to improve or change their image. We may speak disparagingly of these efforts, dismissing them as mere propaganda dreamed up by a slick promoter. In a few instances this may be true; but for the most part, groups that attempt to improve their image are sincere about it.

Obviously, the success of the image improvement depends on action, not merely words. It also depends on each member of the group, who must recognize the need for change and be determined to bring it about.

This month we present a strongly-worded article that asks hospital nurses to check their image, because it's slipping. Although the gist of the message is about personal appearance, the author makes it clear that appearance tells much about attitude. As she says, " . . . usually the professional shows his commitment to his calling by representing it well when on public view."

V.A.L.

letters

Letters to the editor are welcome.
Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Reaction to Minister's speech

The statistics quoted by the Minister of Health in the article "A challenge that confronts us" (Aug. 1969) do not quite tally with those published by the CNA for 1968 – or it may be a matter of interpretation. He stated that "there are over 130,000 registered nurses in Canada . . . and only about five percent of them are in public health work." *Countdown* tells us there are 120,186 registered of which 84,431 are employed. More than eight percent (not five percent) of the employed nurses are working in public health if you include school health and occupational health in that category.

One can speculate that nurses from other countries find employment in northern Canada satisfying because their basic preparation has included study of midwifery and perhaps other services which in Canada are not within the legal realm of nursing. The programs for advanced obstetrics offered at the University of Alberta and for outpost nursing in Dalhousie provide opportunities for nurses to prepare for health services needed in remote Canadian areas, yet practice of those skills in urban Canada would likely be questioned.

I agree with the Minister when he says "reform of health education is possible, is feasible, is practical, and is necessary." It is time the gaps and duplications in medicine, nursing, and other health services were studied to redefine goals and roles. There is a feeling that nurses should be universal substitutes ready to fill in for any health (or administrative) service; this the nurse often does willingly but at considerable risk because she is unprepared. Time spent in non-nursing often means deletion or dilution of nursing care – or delegation to an auxiliary person whose nursing preparation is of a technical nature.

The team approach to health care, for example health clinics, is a more reasonable answer. Hard and fast lines should never be drawn between professional services, yet a more realistic alignment should be studied. – Dorothy Hibbert, Professor, Faculty of Nursing, The University of Western Ontario, London, Ont.

The Honourable Mr. Munro, Minister of Health, in his address has indeed challenged nurses everywhere. The emphasis he placed on health services outside the hospital is significant. Nursing educators have been deeply concerned about the need for educational programs to be developed to include all aspects of health. It is no longer adequate to focus the student's learning experience only with the hospital patient in the acute phase of his physical or emotional crisis. The direction the nursing educational programs have taken is positive for the challenge of expanded health care.

Mr. Munro seems to be embracing the team approach to develop more effective health service. The team has been broadened to include government health and welfare departments, community agencies including hospitals, and the medical and nursing professions.

There is every indication that nursing has been challenged to make a contribution to the plan. In fact, Mr. Munro is calling on nurses to join in the total restructuring of health care services. Let us hope this is true, and when the call is made, Canadian nurses will respond to this challenge with vigor. It is also hoped the provincial governments, health agencies including hospitals, and associations are listening. – M. Geneva Purcell, Director of Nursing, University of Alberta Hospital, Edmonton, Alberta.

The Honourable John Munro has captured our views on nursing and publicly announced his support. Moreover, his suggestions on the expansion of services to encompass the total spectrum of health care – prevention, cure, rehabilitation – have been supported and promoted by nurses for some time. The community comprehensive health program is the only realistic approach to a healthy and productive society.

The double standards under which nurses practice, depending on the locale in which they work, should be reconsidered by both the medical and nursing professions. However, let us not move too quickly to transform nurses into pseudo-doctors, even though there may be individuals with an educational background in nursing who aspire to this role. Such a change will not alleviate the problems facing practicing nurses and the recipients of their care.

A role similar to the Russian feldsher system should not be encompassed wholly by the nursing profession. Nurses have a distinctive and unique function that should continue to predominate in the provision of health care. – Frances Howard, formerly consultant in nursing service, Canadian Nurses' Association.

In favor of lobbyist

I want to tell you that I agree wholeheartedly with your assessment of the association's need for a full-time lobbyist in Ottawa. That this *is* a necessity and possibly may become a reality does not need further discussion.

However, there are numerous thoughts that occur to me, and I would like to share them with you.

First, I wonder if there is much to be learned from the experience of the American Nurses' Association – except perhaps that by combining firmness, friendliness, and femininity, it has eventually achieved a few of its aims, and those only after what must have seemed an interminably long interval. ANA is still plugging away after 22 years trying to amend the Taft-Hartley Act. Fortitude is all very well and good, and so is patience – heaven knows a nurse has plenty of that. But there comes a time when patience wears thin, when firmness and friendliness are of little avail, and when femininity fails us. God forbid that we should ever use our femininity as a weapon. They would turn the tables on us if we did. That is exactly what they want: the opportunity to admire our hats and tell us how lovely we are looking today, and to graciously turn down our proposals, our briefs, our "pure, unadulterated demands."

No, there *are* lessons to be learned from the lobbyists in the USA, but not from the ANA lobbyists. I would not minimize Miss Thompson's accomplishments; they have been considerable. I would only say that in Canada we are dealing with a different type of government, a different type of politician and – despite some evidence to the contrary – a different society than our neighbors to the south. Consequently our tactics will necessarily differ, if they are to be successful.

I think by now CNA has realized there is no percentage in appealing to other members of the health professions to present with us a united front. I believe we should quit trying, as it is a losing battle and a periodic affront to the dignity of every professional nurse in Canada. Remember such remarks as L.R. Adshead's "CNA is poppycock." (News, July 1969, p. 10.)

Instead, I propose that we should turn to big business for help in achieving our goals. I am thinking in particular of those

(Continued on page 6)



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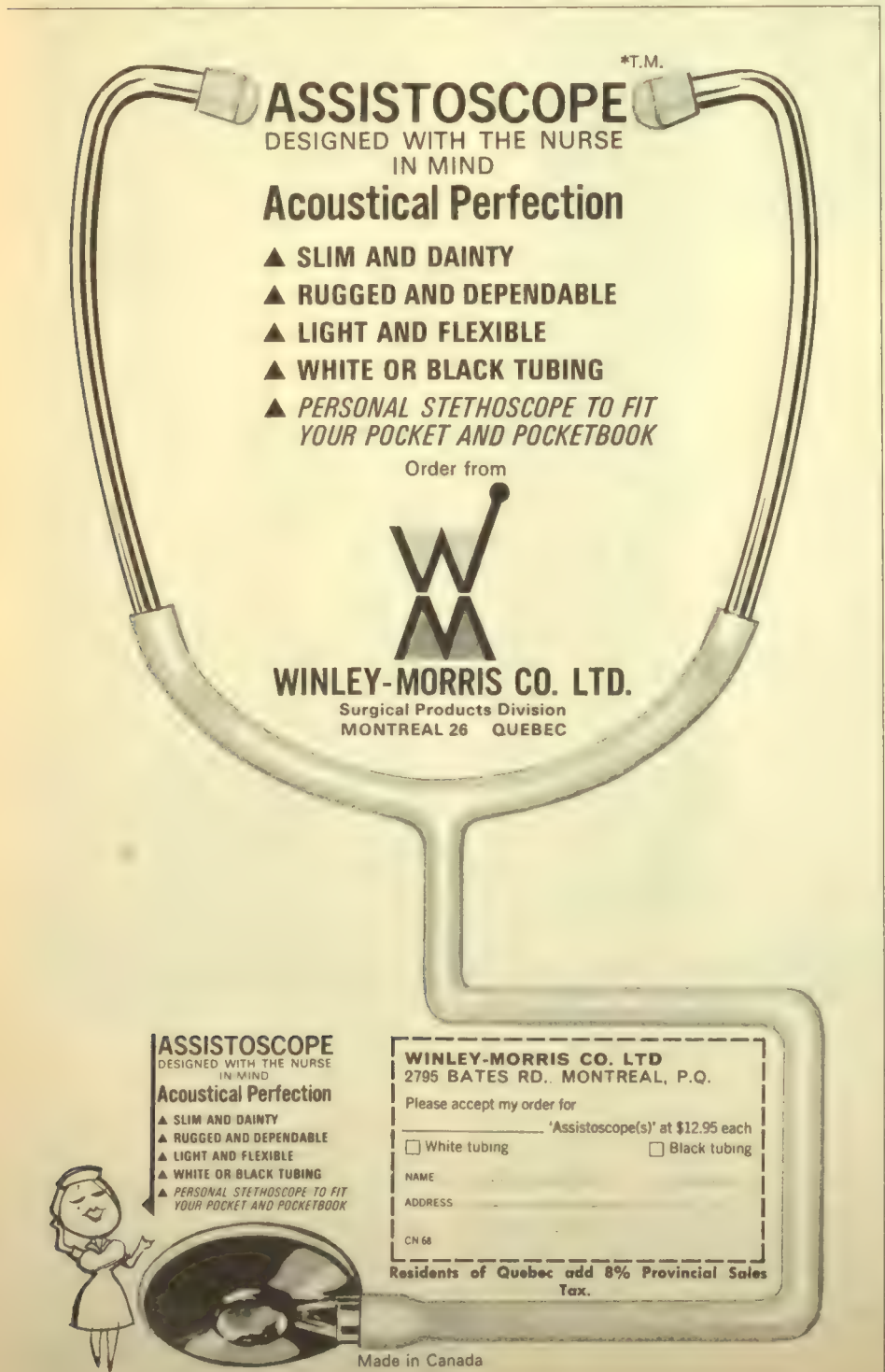
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letters

(Continued from page 4)

who would have a vested interest in seeing that we reach these goals: textbook manufacturers; hospital suppliers (we still do have no small part to play in planning hospital budgets); teaching aid manufacturers; builders and hospital and school planning consultants. I propose that we go to them begging – nurses have always been good at that – for help in the way of lobbying at Ottawa and the provincial capitals, in the way of moral support when our proposals are presented, in the way of pressure of the kind that only big businesses can apply to governments. You may feel that this is a cynical and opportunistic attitude. I suggest that it is only realistic. It seems to me that all else has failed to this point. You must see that.

I propose that now it is time to strip off our gloves, as quickly and efficiently as only nurses can and cease being firm, friendly, fair, feminine *and* foolish. – Mary E. Hall, R.N., Chateauguay, P.Q.



More reaction to article

I have been asked by the executive Committee of the Registered Nurses' Association of British Columbia to express its concern over the publication of the article "Two-Year Versus Three-Year Programs" (February, 1969). Our delay in forwarding these comments was deliberate in order that a copy of the full report might be obtained and studied in conjunction with the article.

The question was first raised at a school of nursing conference where several senior members of school faculties reported conversations with both nurses and non-nurses who had read the article and drawn erroneous and ill-founded conclusions from it. The problem was referred to the RNABC executive committee.

The authors of the study had cautioned the reader: "The results of this study . . . must be interpreted with care and used with equal care as the basis for practical decision-making." Nevertheless, it was apparent that not all journal readers followed this advice. Many of us agree with Dr. Costello's statement (Letters, May, 1969) that " . . . *The Canadian Nurse* deserves more careful reading." We recognize, however, that the majority of nurses do not have Dr. Costello's facility and experience in critically assessing research reports. For these reasons, the members of the RNABC committee on nursing education and the RNABC executive committee are of the opinion that *The Canadian Nurse* has a responsibility, in reporting nursing research, to see that the chances of misunderstanding and misinterpretation are kept to a minimum.

The title of the article in question is, in itself, misleading. The study did not concern "Two-Year Versus Three-Year Programs." It concerned a comparison of a group of graduates from one specific two-year program and one specific three-year program. A further point that seems to have been overlooked by many readers is that the three-year program followed by the control group was a unique one. The article stated only that "both the experimental and the control students followed a program in which repetitions in classes were eliminated, content was enriched and concurrent teaching was introduced."

The detailed report entitled *The Evaluation of a Two-Year Experimental Nursing Program* made it clear that the curriculum of the three-year program followed by the control group was one that had been "subjected to major change":

"The students in the first year of the two-year and three-year programs followed essentially the same curriculum. Students in the second and third years of the three-year program benefited from curric-

(Continued on page 8)



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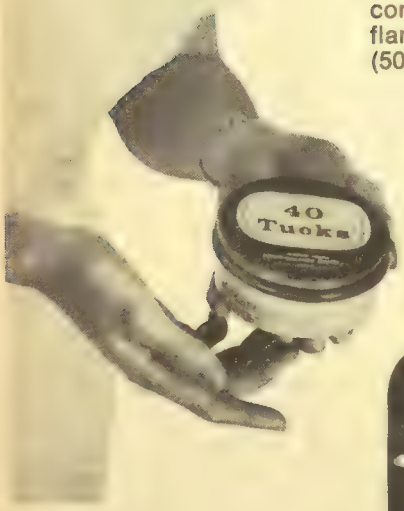
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letters

(Continued from page 6)

ulum reorganization in obstetric and psychiatric nursing areas and nursing of children. Their programs in these areas were 12 weeks in length. They had in addition 48 weeks of experience in general bedside nursing in the service-oriented pattern or it could be described as work experience primarily in medical-surgical nursing."

The authors further reported that, "the same faculty members selected learning experiences for both groups," and further explained,

"By . . . careful selection and reorganization of content, the student was provided with additional time for independent study and library work. However, because the experimental group was one year shorter . . . additional time was given for clinical experience to students in the experimental program, thus reducing their time available for study and library work as compared with the control group."

It can be seen from the foregoing statements that the educational program of the control group was in no way representative of three-year programs offered by the majority of hospital schools.

In their report the authors stated, " . . . the findings in favor of the controls, though not overwhelming, were unexpected." Why the findings should have been unexpected was not explained. Some nurses who have read the report and noted the educational programs of the experimental and control groups have expressed surprise that the differences in performance by the two groups were found to be so minimal. Surely it is not unexpected to find that an additional year of training following two years in an education-centered program should refine and add to a student's nursing skills!

To assist readers to become more knowledgeable in the assessment of research methodology and the interpretation of research findings, the RNABC executive committee would like to urge the adoption of the recommendations made by the RNAO Committee on Research in Nursing in their letter published in June, 1969, that "prior to publication in the journal, research articles be reviewed by researchers who are competent to assess soundness of the design, implementation and reporting of the research," and that "*The Canadian Nurse* invite critiques of articles and research reports for publication, preferably in the same issue or closely following the initial publication of the article, study or report." – F.A. Kennedy, RN, Director of Education Services, RNABC □



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References: 1. Beck, J.W., Saavedra, D., Antell, G.J., and Tejeiro, B.: Am. J. Trop. Med. **8**:349, 1959. 2. Sanders, A.I., and Hall, W.H.: J. Lab. & Clin. Med. **56**:413, 1960.

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CNA Associate Director To Participate In WHO Conference In New Delhi

Ottawa – Lillian Pettigrew, associate executive director of the Canadian Nurses' Association, has been invited by the World Health Organization to take part in a South East Asia Conference to be held in New Delhi, India from November 3 to November 14, 1969. The Conference, organized by WHO, will take the form of a workshop on the control and management of the nursing component of health services.

In her presentation, Miss Pettigrew plans to include a discussion of the role a professional nurses' association can play in influencing the improvement of nursing practice.

The other consultants are Mary Henry, a registered nurse and registrar of the General Nursing Council for England and Wales, whose discussion will center on nursing legislation; a medical administrator, and a part time consultant in legislation for the health professions.

Selected participants have been invited from WHO member countries – Afghanistan, Burma, Ceylon, India, Indonesia, the Maldive Islands (south west of Ceylon), Mongolia, Nepal, and Thailand. Other participants at the conference will include WHO staff from South East Asia, the Western Pacific, and the Eastern Mediterranean region.

Observers have been invited from the International Council of Nurses and the United States Agency for International Development (USAID).

McGill To Offer Master Of Nursing Program

Montreal, P.Q. – The School for Graduate Nurses, McGill University, will offer a one-year program leading to the degree of Master of Nursing beginning September 1970. The course is designed to prepare teachers of nursing for the new educational programs across Canada. Graduates of baccalaureate programs in basic nursing, who have a superior record of academic and professional achievement and development, are eligible for admission.

Supporting the major in the Teaching of Nursing are courses in psychology, sociology, and education. In the field, graduate students will participate in the teaching of nursing by studying how students learn to nurse and by relating conditions for learning to the teaching process.

Closed-circuit T.V., showing videotapes of learning and teaching situations, will provide accessible empirical data for analysis and evaluation. A final internship of two months will permit students a continuous experience in which to examine and develop their teaching practices.

St. John Ambulance Announces Bursary Awards

Ottawa. – The bursary awards committee of the St. John Ambulance Association recently announced its awards for the 1969-70 academic year.

Recipients of the Margaret MacLaren bursary for study at the master's level are:

- Miss Frances Howard, former consultant in nursing service, Canadian Nurses' Association, for study at the University of Western Ontario, London, Ontario;
- Mrs. Marion Estelle Kerr of Beaconsfield Quebec, for study at McGill University, Montreal.

Recipients of The Countess Mountbatten Bursary for postbasic study are:

- Miss Carol Ann Cooper of Toronto, Ontario, to study for the Bachelor of Nursing degree at McGill University, Montreal.
- Miss Heather Lewis of Pointe Claire, Quebec, to study for the Bachelor of Nursing degree at McGill University, Montreal.
- Mrs. Judy Minkus of Winnipeg, Manitoba, to study public health nursing at the University of Manitoba, Winnipeg, Manitoba.
- Mr. Andreas Papadopoullos of Brantford, Ontario, to study for the Bachelor of Science in Nursing degree at the University of Windsor, Windsor, Ontario.

Recipients of The Countess Mountbatten Bursary for students are:

- Miss Kathryn Grant, student nurse, Kingston General Hospital.
- Miss Isabel Hemming, student nurse, Ottawa Civic Hospital.
- Miss Brenda Hunter, student nurse, Winnipeg General Hospital.
- Miss Theresa Hunter, student nurse, St. Joseph's Hospital School of Nursing, Victoria, British Columbia.
- Miss Janice Leask, student nurse, Orillia Soldiers Memorial Hospital.
- Miss Lynne Mannard, student nurse, The Montreal General Hospital.
- Miss Joyce Riehl, student nurse, two-year diploma course, Saskatchewan Institute of Applied Arts and Science, Saskatoon.

New Look In CNA Library



This new browsing stand, donated to the CNA library by an Ottawa book agent, makes an eye-catching entrance display. Here, two staff members examine some of the fare.

Federal Government Nurses Get More Pay

Ottawa. – The Professional Institute of the Public Service of Canada and the treasury board of the federal government signed a new contract August 29 to give the 2,200 federally employed nurses more pay and four weeks vacation after 10 years of service.

Leslie W.C.S. Barnes, executive director of the Institute, said this is the first federal group to have obtained this vacation goal, as virtually all other contracts call for four weeks annual leave after 18 years' service.

The contract is in effect from July 1, 1967 to December 31, 1970. In July 1967, a general duty nurse (Nurse I) earned $4,200 and with 12 increments a maximum of $5,910, depending on the regional area in which she worked. Effective January 1, 1970, she will receive $5,523 with fewer increments to reach a maximum of $7,900. Half-yearly adjustments will be made retroactive to July 1968.

Ethel Gordon, R.N. consultant with the Professional Institute, said that the government has agreed to phase out the

regions that determine how much general duty nurses are paid. Initially, the contract consolidates the present five regional areas into three. "We will be working toward getting a shorter range with higher starting salaries and larger increments," Miss Gordon said. "If there is reason to believe that salaries are not competitive with those outside the government, there is a reopener clause to allow renegotiation before the end of the contract."

Miss Gordon pointed out that a nurse employed at the Nurse I level will receive one increment above the minimum for each two years of recent relevant experience up to a maximum of three increments. In other words, someone with six or more years' recent relevant experience will be earning the fourth step in the salary range on appointment.

Although there is no assistant head nurse classification as such, an assistant head nurse in a federal hospital will receive an additional $380 per year retroactive to January 1, 1968.

The head nurse (Nurse 2) who earned from $6,043 to $6,640 in July 1967 will earn from $7,157 to $8,422 by January 1970. The Nurse 2 level and above is paid at the same rate regardless of the region in which she is employed.

The first level supervisor (Nurse 3), paid from $6,467 to $7,150 in July 1967, will earn from $8,133 to $8,992 by January 1970. Other levels will receive comparable increases with the nurse consultant earning a maximum of $15,720 during the contract period.

The new agreement also provides for financial recognition of university degrees and diplomas; reduced working hours; and compensation for overtime and for assuming responsibilities in remote areas.

The Professional Institute of the Public Service of Canada became the certified bargaining agent for the federally employed nurses on March 3, 1969. The Departments of National Health and Welfare and Veterans Affairs employ most of these nurses. Several nurses work in Canada's northlands.

OR Technicians Form Association

New York, N.Y. – A National Association of Operating Room Technicians was formed in New York July 20. Representatives of over 60 chapters throughout the US voted the establishment of the organization, and adopted bylaws, under the sponsorship of the Association of Operating Room Nurses.

Purposes of the AORT are: to unite operating room technicians; to enable them to study and discuss knowledge, experience and ideas in their area; to promote a higher standard of operating room technician performance; to stimulate interest in ongoing education; and to influence hospitals to employ qualified OR technicians, through cooperative efforts of the AORN and other professional organizations.



Robert W. Eades, elected first president of the Association of Operating Room Technicians, is congratulated by Ina L. Williams, president of the Association of Operating Room Nurses, which sponsored the AORT. Betty Thomas, president-elect of the AORT, looks on.

Robert W. Eades of Rochelle Park, N.J., was elected president of the organization. Ina L. Williams, president of AORN, was chairman of the first national AORT advisory board, made up of AORT members plus representatives of the nation's health industry.

"Miles For Books" Answer To Shortage

St. John's, Nfld. – The clinical areas of the Grace General Hospital in St. John's Newfoundland, were desperately in need of reference books, so the nursing staff found an answer – a long walk. Almost $2,000 was raised by the 146 nurses who walked 11 miles, earning what their sponsors had agreed to pay.

The director of nursing, Mrs. V. Ruelokke, led the field by raising $267.50, as she crossed the finish line. Paul Caraca, a registered nurse in charge of male nurse training, was runner-up by raising $118, and several instructors each raised over $50.

CNA Library Wants Theses

Ottawa. – The library of the Canadian Nurses' Association wants to make its collection of masters' and doctoral theses, prepared by Canadian nurses, as comprehensive as possible.

Margaret L. Parkin, CNA librarian, said that a Canadian nurse attending any university regardless of location is invited to inform her of the topic of the research being conducted and then send a copy of the final paper for the library collection.

By the end of August 1969, nearly 375 studies had been reported and 80 percent were in the CNA collection. The collection is used extensively by nurses as well as by government organizations, and as resource for foreign countries preparing histories of nursing.

Studies may be borrowed on inter library loan or for use in the CNA library.

Breakthrough For Nurses At St. Joseph's Hospital Guelph

Toronto, Ont. – An arbitration board award on September 4, 1969 makes the nurses at St. Joseph's General Hospital in Guelph, Ontario, the highest paid public hospital nurses in Ontario.

"The arbitration award leads to a breakthrough in negotiations for nurses," said Anne Gribben, employment relations director for the Registered Nurses' Association of Ontario. The award was 11 to 15 percent over the Ontario Hospital Services Commission recommended guidelines.

Miss Gribben explained that the original parties for the 1968 negotiations used OHSC guidelines for salaries; however neither the nurses nor the hospital were prepared to negotiate these for 1969. The contract was opened to negotiate salaries for 1969.

Under the terms of the new contract that expires in December 1969, general duty nurses will earn $525 per month

(Continued on page 15)

NEW IN 1969

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By Barry G. King, Ph.D., U.S. Public Health Service, and Mary Jane Showers, R.N., Ph.D., Hahnemann Medical College.

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Sutton: BEDSIDE NURSING TECHNIQUES IN MEDICINE AND SURGERY New 2nd Edition

By Audrey Latshaw Sutton, R.N., Blue Cross of Philadelphia, formerly of Edgewood General Hospital, Berlin, N.J., and Wilmington (Del.) General Hospital.

Used by more than 80,000 nurses, "Sutton" is one of the most widely used books of its type ever published. The new, revised Second Edition is a completely up-to-date source book of clinical nursing procedures. In clear, simple language supplemented by more than 850 drawings, the author tells precisely how to perform hundreds of nursing functions — from intramuscular injection to care of the patient in hyperbaric oxygen therapy. You'll find new data on such topics as: reverse isolation, IPPB respirators, hypodermoclysis, tubeless gastric analysis, heart transplants, and fluid and eletrolyte balance.

398 pages with 871 illustrations. $8.95. Published March, 1969.

Marlow: TEXTBOOK OF PEDIATRIC NURSING 3rd Edition

By Dorothy R. Marlow, R.N., Ed.D., Villanova University.

The most widely used text in its field, "Marlow" has been completely revised and brought up to date in its new Third Edition. It remains an unexcelled presentation of the growth, development, and nursing care needs of the sick and well child from birth through adolescence. For each stage of development, Dr. Marlow describes normal growth and behavior patterns, health requirements, and conditions requiring immediate, short term, and long term care. She emphasizes the nurse's role in dealing with the emotional problems of the child patient and his family.

687 pages with 572 illustrations. $9.20. Published May, 1969.

Simmons: THE NURSE-PATIENT RELATIONSHIP IN PSYCHIATRIC NURSING

By Janet A. Simmons, R.N., M.S., University of Massachusetts.

This new workbook fills a need unmet by anything previously available. It helps the student nurse establish a therapeutic relationship with a mental patient during her institutional affiliation in psychiatric nursing. Each of the thirteen guides covers a specific aspect of the process — from orientation and communication to final evaluation. There are questions for the student to answer and places for her to record her observations. A problem-solving approach is used throughout. This book has been thoroughly tested in actual use by classes of nursing students.

189 pages. Soft cover. $4.05. Published August 1969.

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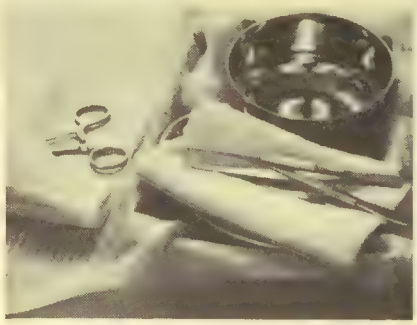
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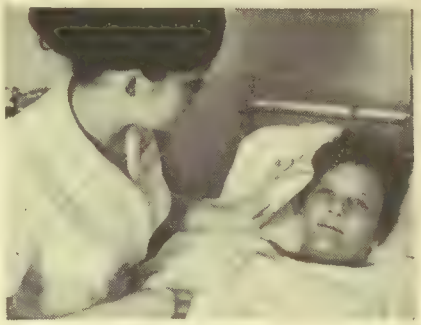
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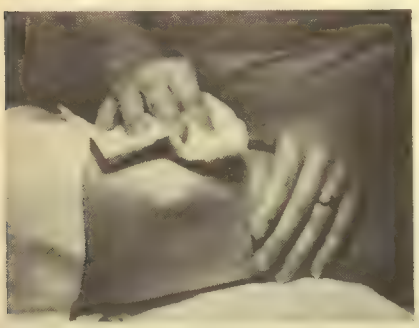
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news

(Continued from page 12)

with a maximum of $650 based on increments of $25 per month annually for five years. A graduate non-registered nurse will earn from $500 to $625, and an assistant head nurse $563 to $688. The daily rate for registered nurses working part-time will be $28 and for graduate non-registered nurses, $25.50.

Professor Earl Palmer, associate dean of the faculty of law at the University of Western Ontario and head of the arbitration board, said in his report: "The board wishes to note that we have paid no consideration whatsoever to statements of the Ontario Hospital Services Commission. In our opinion, the intentions of this body are completely irrelevant to our deliberations. We cannot accept the position that the public is entitled to nursing services by virtue of legislatively forcing nurses to accept substandard wages."

CCUSN (A) Submits Brief To Maritime Union Study

Halifax, N.S. – The Canadian Conference of University Schools of Nursing, Atlantic Region, submitted a brief to the Maritime Union Study (a commission set up by the three Maritime provinces to study the feasibility of union) on September 3, to demonstrate the present and future need for cooperation among the university schools of nursing in the region.

CCUSN (A) believes that money, a sufficient number of qualified teachers, and planning and coordination are equally important.

In the brief, CCUSN (A) reviewed the present and future needs of higher education for nurses in the Region and tried to indicate the support necessary to provide the kind of higher education that today's society requires.

Because there is an urgent need for more highly qualified nursing personnel on faculties of university schools of nursing, CCUSN (A) believes there should be within each Maritime university supporting a school of nursing, salary scales, status, and working conditions that are competitive with university schools of nursing in other areas of Canada and with their colleagues in other faculties within the university community. Plans should be developed to enable nurses to obtain higher degrees to qualify for university appointments, the brief continued.

CCUSN (A) recommended the development of publicity on a regional basis to attract more students into the program, and that present obligations required by bursary recipients be made less restrictive.

CCUSN is a national organization subdivided into four regions, of which the Atlantic region is one. Each region is organized with its own executive and constitution to permit free exchange and collaboration that provides a voice to speak for nursing education within the university.

"Good Samaritan" Act Passed By Alberta Legislature

Edmonton, Alta. – The Emergency Medical Aid Act to give protection from actions for damages to certain persons rendering medical aid as a result of an accident or in an emergency was passed into law May 7, 1969, by the Alberta legislature.

According to the *AARN Newsletter*, full credit for such action goes to the Pincher Creek Chapter of the AARN, which requested the executive to seek such legislation. Their brief presented to the Alberta Cabinet in January brought favorable results.

The Act reads as follows:

1. This Act may be cited as the Emergency Medical Aid Act.
2. In this Act.
   a) "physician" means a person who is registered as a medical practitioner under The Medical

(Continued on page 17)



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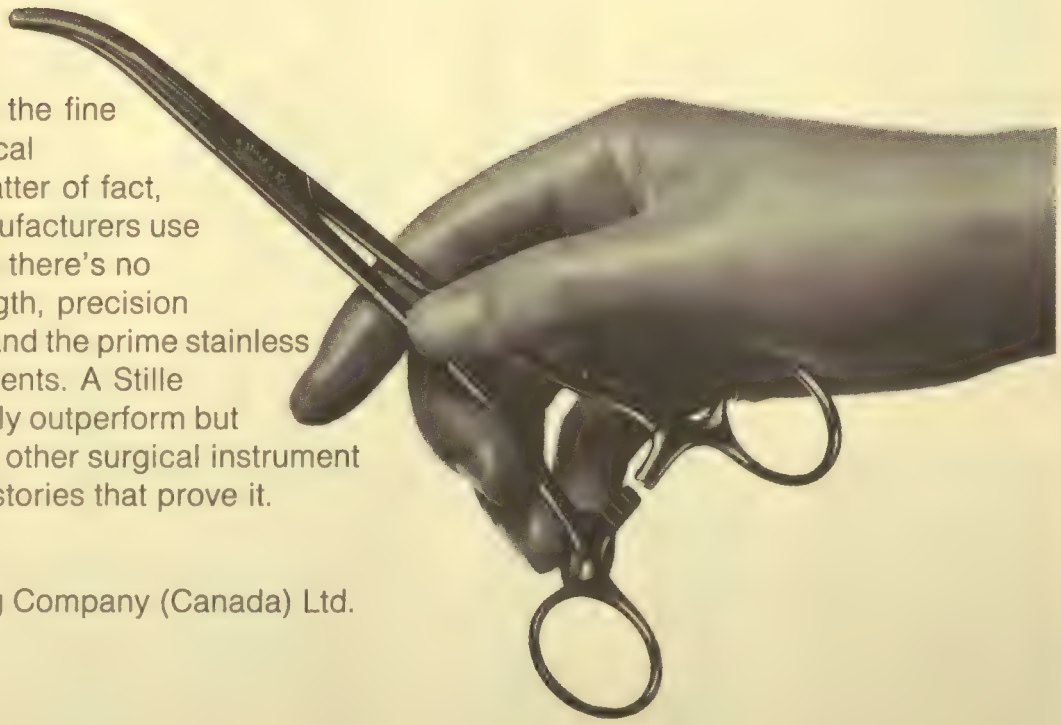
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(Continued from page 15)

Profession Act;

b) "registered nurse" means a person who is a registered nurse under the Registered Nurses Act.

3. Where, in respect of a person who is ill, injured or unconscious as the result of an accident or other emergency,

a) a physician or registered nurse voluntarily and without expectation of compensation or reward renders emergency medical services or first aid assistance and the services or assistance are not rendered at a hospital or other place having adequate medical facilities and equipment, or

b) a person other than a person mentioned in clause (a) voluntarily renders emergency first aid assistance and that assistance is rendered at the immediate scene of the accident or emergency,

the physician, registered nurse or other person is not liable for damages for injuries to or the death of that person alleged to have been caused by an act or omission on his part in rendering the medical services or first aid assistance, unless it is established that the injuries or death were caused by gross negligence on his part.

Management Nurses Organize In New Brunswick

Fredericton, N.B. – Directors, assistant directors, and associate directors of nursing have formed a Management Nurses' Organization under the New Brunswick Association of Registered Nurses. The idea for the group's formation resulted from the Public Service Labour Relations Act of New Brunswick, which excludes nurses in managerial positions from collective bargaining. More than 55 management nurses are members.

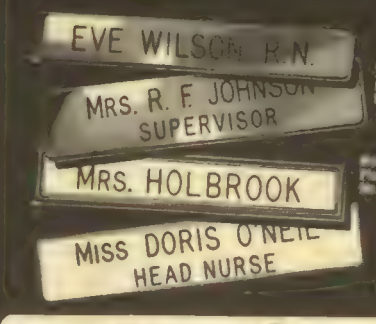
A core committee of five, representing the five health regions of the province, met September 26 to develop guidelines for the new organization that is open to all management nurses. The guidelines referred to the group in each region for consideration have not yet been released.

Quebec School Children Suffer From Malnutrition

Quebec City, P.Q. – In 1968, 508,519 school children had physical examinations in the province. Of these, 55,604 had deficiencies that could affect physical maturity. The majority were

(Continued on page 19)

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McMaster University, Hamilton.
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malnourished or suffering from fatigue. Visual difficulties centered on strabismus, myopia, and hyperopia.

Doctors visited kindergarten classes, diagnosed problems, and suggested treatments to give the children a better chance at school. They were particularly interested in the children's neuromotor systems, their mental and emotional states, and their social adjustments.

Family doctors and health unit personnel became more aware of physical, mental, and social problems of the school-aged child as a result of the school program. Seven hundred nurses spent 30 percent of their time in elementary schools and 56 nurses worked in secondary schools in 1968. Depending on the number of students, from one to five nurses worked in each of the 55 regional school boards in Quebec.

The department of health is interested in treating the very young child in the hope that future physical or intellectual problems based on neglect can be avoided.

Committee To Investigate Nonmedical Use of Drugs

Ottawa. – The Honorable John Munro, minister of national health and welfare, has announced the appointment of a committee to investigate the nonmedical use of drugs. The committee, composed of M. Gerald Le Dain, Ian Lachlan Campbell, André Lussier, J. Peter Stein, and Dr. Heinz Lehmann, will gather information from Canada and abroad.

They will prepare a report on the extent of current knowledge about the nonmedical use of drugs; the reasons underlying the use of the drugs; the social, economic, educational, and philosophical influences of the use of drugs; and suggest ways that the federal government can reduce and remedy the problems caused by drug use.

A preliminary report will be made after six months and the final report after two years.

WHO Work In Africa Continues

Geneva, Switzerland. – The World Health Organization has intensified its efforts to train doctors, paramedical staff, and auxiliaries in Africa. In his annual report to the WHO Regional Committee for Africa, Dr. Alfred Quenum, the regional director, said the shortage of qualified health staff, the unsatisfactory distribution of the small number available, and their depletion owing to the brain

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news

drain are still the main obstacles to the development of public health services.

Dr. Quenum said one important feature of the work done in education and training was the orientation given to most of the programs set up according to the countries' needs and tasks to be accomplished. Educational objectives, curricula, and teaching methods reflected these tasks, and were applied at the postbasic nursing education center in Dakar that opened recently with 20 students from various French-speaking countries, Dr. Quenum reported.

WHO has also extended help in the establishment of the African Region's first University Centre for Health Sciences in Yaoundé, Cameroon, he said. The Centre will be a new type of training and research institution, specially designed to meet local health needs, provide a high quality multi-professional program for all members of the health team, and develop new concepts of the function of auxiliaries. "We are placing great hopes in this scheme, since if it succeeds the problem of training nationals capable of taking over responsibility for the medical services of their countries will be partially solved," he said.

Old Age Pension To Increase In 1970

Ottawa. – The Honorable John Munro, minister of national health and welfare, announced in August that increases in the Old Age Security Pension and the Guaranteed Income Supplement will take effect in 1970.

Mr. Munro and Revenue Minister J.-P. Côté jointly announced similar increases in Canada Pension Plan retirement pensions, survivor's benefits and contributions effective next year. Cheques issued in January will reflect these increases.

The 1970 OAS pension will be $79.58 per month. More than 1,600,000 Canadians will benefit, including those whose pensions will begin in January when the eligible age will drop to 65 years. In addition, 780,000 OAS pensioners will benefit from an increase in the Guaranteed Income Supplement. The 1970 GIS payment will be $31.83.

Mr. Côté announced that maximum annual pensionable earnings under the Canada Pension Plan will reach $5,300 in 1970, compared to $5,200 in 1969.

At the end of 1969, Mr. Munro estimated that more than 140,000 Canadians would be receiving monthly retirement pensions and survivor's benefits under the Canada Pension Plan. The maximum death benefit payable under the Plan, for deaths in 1970, will be $530. □

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names

Margaret E. Walsh (B.S.N., Catholic U. of America; M.N., U. of Pittsburgh) has been appointed general director of the National League for Nursing. She succeeds Inez Haynes. Mrs. Walsh has held nursing posts with veterans administration hospitals in Pittsburgh, Pa., Brooklyn, N.Y., Madison, Wis., and in Washington, D.C. She has been a clinical associate in the department of medical nursing, University of Pittsburgh, and has held a position in nursing administration at the Catholic University of America. Prior to her new appointment, Mrs. Walsh was president of the District of Columbia League for Nursing.

Gladys Sharpe (Reg.N., Toronto Western Hosp.; B.S., Columbia U.; cert. in admin. in schools of nursing, London U.; cert. in teaching, McGill U.) was awarded an honorary doctor of laws degree by McMaster University in May.

The degree was conferred in honor of a "Tireless worker with global perspective, whose dedication and compassion have been reflected in remarkable accomplishments during the varied stages of her professional career," according to her citation. Miss Sharpe has left nursing after 42 years in the profession to become a nursery school teacher.



Sister Elizabeth Hurley (R.N., St. Joseph's Hosp., St. John, N.B.; B.Sc.N., U. of Seattle) recently was appointed director of nursing service at St. Vincent's Hospital in Vancouver.

Previously Sister had been a general duty nurse and supervisor at St. Joseph's Hospital, Saint John, N.B.

A well-known Canadian nurse died suddenly in August of injuries received in a car accident. **Dorothy Warner** (R.N., The Montreal General Hosp.; cert. in admin. in schools of nursing, McGill U.) died August 9 in Kenora, Ont.

Miss Warner began her career as a general duty nurse in Medicine Hat, Alberta, and in Anson General Hospital, Iroquois, Ont. During the Second World War, she became principal matron at National Defence Headquarters, and later Matron-in-Chief, NDHQ. At the time of her death she was chief nursing officer, the St. John Ambulance Society, and head of volunteers at the Ottawa Civic Hospital.

Dr. Lossing Retires



Dr. E.H. Lossing, former Director General of Health Insurance and Resources Branch of the Department of National Health and Welfare, was honored by friends on his retirement at a reception and dinner. Here Margaret D. McLean, Senior Nursing Consultant, presents a bouquet of roses to Mrs. Lossing as Dr. Lossing looks on.



Arlene Aish (B.S.N., U. of British Columbia; M.N., U. of Washington) has joined the staff of the school of nursing, Queen's University in Kingston as assistant professor.

Miss Aish spent a year at The Vancouver General Hospital as a staff nurse, then joined the City of Toronto Health Department as a public health nurse. She spent four years at the University of Toronto as lecturer, and two years at the University of Fredericton as assistant professor. She joined Queen's after a year of post master's work at the University of California, San Francisco.

Douglas Hospital, Verdun, Quebec, has announced the retirement of its director of nursing, **Mary Christie** (R.N., Hamilton General Hosp.).

Mrs. Christie nursed in Hamilton and St. Thomas, Ontario, before joining the Royal Canadian Army Medical Corps in 1942. She spent three years in South Africa with the South Africa Military Nursing Service.

After the war, Mrs. Christie worked at the Shriners Memorial Hospital and the Allan Memorial Institute in Montreal. In 1948 she went to Douglas Hospital as an instructor, and became director of nursing in 1958.



Replacing Mrs. Christie is **Nessa Leckie** (R.N., St. Paul's Hosp., Saskatoon; B.Sc.N., McGill U., Montreal).

Miss Leckie has been affiliated with nursing education in three large mental hospitals. After becoming assistant director of the school of nursing at Douglas Hospital in 1960, she reorganized and enlarged the program for psychiatric nursing assistants.

In 1966 Miss Leckie helped reorganize nursing education at St. Ann's Hospital, Port-of-Spain, Trinidad, as part of the federal government's External Aid team to the Caribbean. The school of nursing at Douglas Hospital continues to accept many students from the Caribbean.

Nora Earle (R.N., Hamilton General Hosp.) has been made a member of the Royal Society of Health.

Mrs. Earle is head nurse of school health services, Lakeshore Regional Board, Pointe Claire, Que. She is also a Fellow of the American School Health Association. □

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October 14-15, 1969
Respiratory Care Conference, The Winnipeg General Hospital, Winnipeg. Write to: Mrs. Slessor, The Winnipeg General Hospital, 700 William Ave., Winnipeg 3, Manitoba.

October 15-17, 1969
Health Care for the Stroke Patient, a continuing education course for health professionals, sponsored by the University of British Columbia. Tuition: $20. The course will be held at The Arthritis Centre, 895 West 10th Avenue, Vancouver, B.C. Address inquiries to: Division of Continuing Education in the Health Sciences, Task Force Building, The University of British Columbia, Vancouver 8, B.C.

October 16-17, 1969
Continuing Nursing Education Course in Nursing the Adult with Long Term Illness. The University of British Columbia, School of Nursing, Vancouver, B.C.

October 24, 1969
Catholic Hospital Conference of Ontario Nursing Committee meeting, Westbury Hotel, Toronto.

October 25, 1969
Fraser Valley District Registered Nurses' Association of British Columbia Education Day, Chilliwack, B.C., Evergreen Hall Auditorium. Fee: $5.00. Write: Mrs. Mary McCallum, 127 Princess Ave. E., Chilliwack, B.C.

October 25-26, 1969
Catholic Hospital Conference of Ontario, annual convention, Westbury Hotel, Toronto, Ontario.

October 30-31, 1969
Continuing Nursing Education Course in Pediatric Nursing. The University of British Columbia, School of Nursing, Vancouver B.C.

November 3-6, 1969
Operating room seminar, sponsored by the American Sterilizer Co., Park Plaza Hotel, Toronto. For more information write to: American Sterilizer Co. of Canada Ltd., 255 Queen E., Brampton, Ont.

November 4-7, 1969
American College of Hospital Administrators, seminar on executive skills, Cornwallis Inn, Kentville, Nova Scotia. Write to: American College of Hospital Administrators, 840 N. Lake Shore Dr., Chicago 60611, Illinois.

November 11-13, 1969
Quebec Operating Room Nurses' Group, annual convention, Skyline Hotel, Montreal.

November 12-14, 1969
A continuing education course for nurses: "nursing the adult with an altered state of consciousness." University of British Columbia School of Nursing. Fee: $20. Write: Division of Continuing Education in the Health Sciences, Task Force Building, University of British Columbia, Vancouver 8, B.C.

November 13-14, 1969
Continuing Nursing Education Course in Nursing the Adult with Acute Illness. The University of British Columbia, School of Nursing, Vancouver, B.C.

November 17-21, 1969
World Mental Health Assembly, sponsored by the World Federation for Mental Health and the National Association for Mental Health, Washington, D.C. Theme: Mental Health In The Community. Write to: Dr. Paul V. Lemkau, Chairman, World Mental Health Assembly, 615 N. Wolfe St., Baltimore, Md. 21205, USA.

November 19-21, 1969
2nd Manitoba Health conference, Fort Garry Hotel, Winnipeg, Manitoba. The theme of special sessions for November 20, planned by the Manitoba Association of Registered Nurses, is Community Health — Planning for Progress. Another special session topic will be Providing Continuity of Care — The Home Care Program: Community Or Hospital Based. For more information write: The Manitoba Association of Registered Nurses, 647 Broadway, Winnipeg 1, Manitoba.

November 24-28, 1969
Nurse educators' course on disaster nursing, Canadian Emergency Measures College, Arnprior, Ontario. Nurse educators from English-speaking schools of nursing are encouraged to enroll. Preference will be given to representatives from schools of nursing that have not incorporated disaster nursing in their student nurse curriculum. For further information write to the director of emergency health services in your provincial department of health.

November 26-28, 1969
Fourth annual convention of the Canadian Society of Inhalation Therapy Technicians, Calgary. For information write: Mr. E. Zaiss, Convention Chairman, Rockyview Hospital, Calgary, Alta. □



a little knowledge is not enough . . . give teen-agers the facts about menstruation

Some teen-agers have heard they shouldn't bathe or wash their hair during their menstrual periods. Some think unmarried girls shouldn't use tampons. Others say exercise brings on "cramps." No wonder they call it the "curse."

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Unmarried girls, of course, can use tampons. And they have many good reasons to do so. Tampax tampons are easy to insert—comfortable to wear. Because they're worn internally there's no irritation or chafing; no menstrual odor.

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Esso bee

The May issue of *Ontario Medical Review* carried a clinical report dealing with the habits of bees. At a particular intersection on a highway with a service station on each corner, it was noted that swarms of bees swoop down each summer to hover around the Shell station, with one or two going across the highway to the Esso station. The conclusion of the research was that in every swarm there was at least one Esso bee.

Spicy wrapping

It may not be long before those infuriatingly secure packages won't have to be removed from food for cooking. The packages may soon become part of the meal.

An Associated Press story from Chicago reports that Dr. J.F. Murphy, a vice-president of Swift and Company, told the National Restaurant Association that scientists are working on proteins that will dissolve at cooking temperatures.

"We may even offer a choice of flavored boxes, wrappers, or bottles to complement or spice up the rest of the meal," he said.

Meal's no great shakes, but that box – it's delicious.

Color conscience

Have you ever wondered why it is some people go for colors that merely seem frumpish, loud, or plain awful to you? Everyone discriminates in color, but there has been little research into the reasons for the discriminations.

Extensive tests have convinced some scientists, however, that there is a reason. Colors on the red side of the spectrum, they say, are warm and stimulating, whereas their blue and green opposites are cool and relaxing.

This is nothing new? Well, consider the following evidence reported by the June issue of *Hospital World:*

Muscular responses are faster under a light shade of red; green retards reactions. Many people tend to overestimate the passage of time under the influence of strong colors of red and underestimate it under equally strong influences of green or blue.

Blue can be an emotional sedative, and some hospitals have found that patients recover more quickly in blue rooms. Although yellow shades are believed to be capable of producing a warm sensation, just a slight change in shading can cause a feeling of nausea. Commercial airlines long ago abandoned interior decorations in yellow because tests showed certain shades seemed to encouraged air sickness.

Factory workers complained they were straining their backs lifting black metal boxes in one factory. The foreman suggested repainting them a pale green. After this, a number of men commented on the ease of lifting those new lightweight boxes!



Fitness is the ideal

The ideal woman, apparently, is the physically fit woman. According to the Reverend Thomas Boslooper of Closter, N.J., "Most outstanding women are physically active in one way or another. They also tend to make the best wives and mothers because they have the fewest emotional problems."

The Reverend Boslooper conducted a 10-year study on the subject, interviewing 300 "women of accomplishment" and 150 husbands. He began his study because he was called upon to counsel women with marital problems and decided to go to women who had been successful to see how they did it.

"The general finding was that all mature, intellectually creative women were tomboys when they were young," he said. "Emotionally healthy women love the competition a sport offers, while emotionally distraught women cannot cope with competition."

Uniform uniforms

A medical student spent his summer working in a variety of jobs to finance his education. One time he assisted a butcher by day and was an orderly by night. Both jobs required similar white uniforms. One evening he was assigned to push a patient on a stretcher into the operating room. As he entered the room, the patient looked at him and looking up again began to scream: "Good heavens! It's my butcher!" – *CHAC Bulletin,* June 1968. □

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Making a comeback

Believing that hospitals needed all the staff they could get, the author took a refresher course so that she could return to nursing. However, it wasn't all that simple. She began to think it might be easier to get a part-time job with Office Overload.

B. Kowalchuk

"Come back to nursing – nursing needs you! " In recent years this plea has been directed to those of us who are almost middle-aged and retired from active nursing. Radio and television broadcasts urged us to help reduce the hospital nursing shortage by returning to work. Even subway posters, showing the older nurse pinning on her cap to return to work, exhorted us to come back to the fold. It seemed that we could no longer enjoy a shopping excursion or a free afternoon without a pang of conscience.

Eventually these appeals reached me. I took one of the six-week refresher courses offered by the Registered Nurses' Association of Ontario, because I believed all hospitals were short staffed and would appreciate a few hours a week of my time. Also, the thought of working in a hospital again appealed to me.

The course gave me the opportunity to update my theoretical knowledge and practical skills. My self-confidence grew as I realized I had not forgotten as much as I feared, and everything was not as new and different as I anticipated. In short, I knew it would take me only a brief period to readjust to active nursing and don the uniform and cap to work as a nurse. My husband gave his whole-hearted support. "Go ahead and do what you want," he said, "as long as it doesn't interfere with my comings and goings."

With the refresher course behind me and the certificate to prove it in hand, I was ready to go back to hospital work – I thought. But getting a job that suited both the hospital and myself was not easy. The hours I was able to work were not the hours the hospital wanted me to work. Apparently I was not alone in this dilemma: most of my refresher-course colleagues were facing similar situations.

Some hospitals were willing to accept us part-time but with a fair share of shifts and weekends. We were caught in the middle – our families protested when we were out working and they were at home; the hospitals complained when we wanted to work only days and certain hours at that. "We'll put your application on file and call you if we need you," was the usual response.

I had thought we *were* needed. I began to think, however, that it would be easier to get a satisfactory part-time job with Office Overload!

I don't blame either part involved in this predicament. When a wife works all day, the household may be rather frantic by the time the husband gets home from work. Hot dogs heated up by his young daughter, and a somewhat frenzied atmosphere created when a teenage son has been left in charge, are rarely a welcome reward for providing the family with necessities and luxuries.

On the other hand, most hospitals appear overstaffed on the weekday 8:00 a.m. to 4:00 p.m. shift. I had noticed this as a patient and from my observations during clinical experience in the refresher course.

Another fact is often overlooked. The middle-aged married nurse may have a multitude of household details to attend to as well as her job. She may not be as energetic as the 22-year-old unmarried, new graduate. Eight hours of continuous physical exertion can be rather grim unless you can go home and relax for a few moments. Along with many others in my age group, I do not wish to be exhausted and irritable half the time. I would like merely to keep my mind alert, and my nursing skills up-to-date, and be of some assistance to people.

I believe there is an answer to this dilemma. The two peak periods in the nursing day are from 8:00 to 12:00 morning and evening. In the morning, baths are given, beds are changed, most treatments and medications are given, and patients are visited by their doctors. Frequently the same treatments are repeated in the evening. Many things could and should be done to ensure the patient a good night's sleep. By comparison, 12 noon to 8:00 p.m. and 12 midnight to 8:00 a.m. are reasonably light in most units.

I believe that only the peak hours described above need *extra* nurses. These hours would be best for the refresher course graduate to make her reappearance.

Let us look at it from both points of view. If the nurse worked only four hours, she would perhaps be less tired and less irritable with her family. The majority of reasonable husbands would not object to the occasional four-hour evening or weekend morning. Theoretically, hospitals should not complain because they would be receiving extra help when they needed it most – during peak hours.

The half-shift system for part-time nurses is not new. A few of the smaller hospitals still use it. Why is this system not adopted by the larger hospitals? Probably because it involves extra book work for the nursing office staff.

However, hospitals exist only for patients. And patients would benefit from the extra care that additional, part-time staff could give during peak hours.

In the meantime I am still looking for the ideal job. It will keep my family happy, benefit patients, give me mental stimulation, and provide some pocket money as well.

But perhaps I am searching for Utopia. □

Mrs. Kowalchuk, a graduate of Brantford General Hospital, was case room head nurse at the Toronto East General Hospital for several years. The mother of three children, she still finds time to write short stories and articles for publication.



The child with leukemia

Knowing that leukemia robs children of normal experiences, the nurse caring for these children tries to make the most of the present. She attempts to alleviate some of the problems faced by the child and his parents and make their time together happier.

Catherine E. Cragg

"How can you stand to work on a ward where the children have leukemia?" "Don't you find it depressing?" These questions are frequently asked by those unfamiliar with our ward at The Hospital for Sick Children, Toronto. Although approximately half of our 23 patients have leukemia, the ward is not gloomy. Satisfactions for the nursing staff come not from seeing our patients go home cured, but from believing that our care has helped affect the course of the illness. If we can alleviate some of the problems faced by the child and his parents and make their time together happier, our nursing care has been of value. We cannot be depressed by that.

Admission usually difficult

We usually see the child at intervals throughout his illness. After his first admission for diagnosis and beginning of treatment, the hematologists see him as an outpatient until he is readmitted to the ward for reassessment, chemotherapy, or treatment of complications. Admissions may last one night or several months. The child may appear well or be critically, even terminally, ill.

The first admission is difficult. Suddenly, after a period of feeling unwell and lethargic, of having persistent infection, pain, or abnormal bleeding, the child is admitted to hospital. Most of our patients are between two and six years of age.

Hospitalization and separation are difficult for any preschool child. It can be terrifying when the admission is sudden, parents are obviously upset, and strangers perform painful procedures such as bone marrow aspirations. Some children protest by crying, squirming, refusing medications, avoiding ward personnel, clinging to mother, and attempting to climb out of bed to follow her. Others withdraw into the lethargy the illness has already produced. Older children may show signs of depression if they guess the seriousness of the illness. Life has suddenly changed; it will never be the same again.

At the time of diagnosis, we begin a lasting relationship with the child. The more we know of him and his family, the more we can help. We have to accept his protests as understandable. We try to draw him out and learn as much about him as we can. First, we talk to his parents and have them answer a questionnaire about his habits and behavior at home. As we learn how he reacts to being in hospital and being ill, we exchange information so that all members of the nursing staff are aware of his likes, dislikes, and special needs. Changes in assignment are kept to a minimum so that

---

Miss Cragg is a graduate of McGill University. She has worked as a general duty nurse in Vancouver and at The Hospital for Sick Children, Toronto, where she is now head nurse on one of the medical units.

he can learn to trust a few nurses. We want the child to feel that when he is readmitted he will be known, welcomed, and accepted.

Chemotherapy is used to induce remission of the disease. When relapse occurs after treatment with one drug or a combination of agents, other drugs are used. As well as using the common anti-leukemia drugs, the hematologists use research drugs to determine their effectiveness. Most of the anti-neoplastic agents are highly toxic because they affect normal cells as well as leukemic ones. Many of the physical problems with which we must deal are created by the treatment.

Because the disease interferes with the production of normal red and white blood cells and platelets, and because therapy depresses the bone marrow's production of blood cells, anemia, bleeding, and infections are common. We watch for nosebleeds, blood in stool or urine, petechiae, and bruising. Hemorrhage is potentially fatal and must be treated promptly. We apply firm pressure to venupuncture sites to prevent hematomas. We have a nasal packing tray on hand in case simple pressure does not stop a nose-bleed. Transfusions of packed cells and platelet concentrate are used to stop bleeding and treat low platelet levels. Since patients who have had many transfusions are more likely to have reactions, they must be carefully observed during transfusions.

Lack of normal white blood cells reduces the patient's ability to combat infections. Bacteria normally present in the gastrointestinal tract can cause high fevers, septicemia, and fulminating infections. High doses of antibiotics are given intravenously to combat infection. Occasionally the child is isolated to protect him from the environment. Traffic through the ward area is minimal and the children with leukemia are placed in rooms away from the main door and from children who might be sources of infection.

Intravenous infusions are important for administering blood and its products, anti-neoplastic drugs, antibiotics, and sedatives. They are frequently difficult to start in the child who has had many intravenouses and venupunctures and who has hematomas and thrombosed veins. Once the doctor has started the intravenous, it is the nurse's responsibility to protect and maintain it. The children dread the treatment room because starting an intravenous can be a long, painful procedure. The nurse supports the child physically and emotionally during the time of fear. He quickly learns to protect his intravenous, and an armboard is usually the only restraint necessary.

Life kept normal

During intravenous therapy, we keep life as normal as possible. We dress the child in up-patients' clothing during the day and arrange for activities that are possible with an intravenous running. We attach a pole to a stretcher or wheel chair so that the child can go into the hall and to the ward playroom. We teach the parents to pick up the child even with the intravenous so that physical contact is maintained. The parents quickly learn to recognize and report signs of trouble.



Procedures such as bone marrow aspirations and lumbar punctures loom large among the child's fears. We give him little warning of a procedure so that worrying about it will not ruin his day. During the procedure he is the nurse's main concern as she holds him firmly but gently. She tells him what is happening behind him and explains that keeping still will speed the procedure and avoid repetition. Most of the children learn not to move. They can cry as much as they want; we encourage the quiet child to protest. "Say 'ouch' when it hurts," lets him know we expect tears. A Band-Aid is important as proof the procedure is over and as a badge of courage.

Pain is a frequent and serious problem, especially in the terminal phase of leukemia. As the disease progresses, it may infiltrate bone, brain, abdominal organs, and other areas. Headache and dull, wearing, abdominal pain, or vague general discomfort, make rest impossible. Movement can make pain in bones and joints excruciating. Frequently, the young child will not say he has pain or cannot identify it. He may be shy, fear needles, or fear that pain will keep him from going home. Often he will tell only his parents or a nurse he trusts. Increased irritability, restlessness, reluctance to move, and crying, holding, or guarding reveal that the child is having pain.

The nurse must assess the degree of pain. Sometimes the child complains because he needs more attention, and apprehension can magnify pain. Changing position, giving back care, providing a restful environment, companionship, and diversion can be as important in reducing pain as giving drugs. Usually when analgesics are required, narcotics are used. The nurse must decide when medications ordered p.r.n. are indicated and must report to the doctors if the relief they produce is inadequate.

The child with leukemia frequently has a poor appetite. During relapse, he is often too lethargic to eat. Anti-neoplastic drugs, radiation, and central nervous

system involvement can cause nausea and vomiting. Medication can cause severe ulceration of the mouth and gastrointestinal tract. Nasal bleeding, with its clots and packing, makes eating difficult and food unpalatable. When eating is tiring and painful, it is easier simply to stop.

Foods that tempt children, such as soft drinks, sugared breakfast cereals, potato chips, and hot dogs, are not necessarily nourishing. The children develop fads in eating; one week chicken noodle soup will be the choice, and the next, spaghetti. When an anorexic child does want food, he wants it immediately.

Maintaining a balanced diet is almost impossible. At each meal we present food as attractively as possible and try to persuade the child to eat as much as he can. We provide drinks and snacks whenever he asks for them; he can have ginger ale or hot dogs at all hours. We encourage parents to bring nourishing foods the child likes. Mummy's soup seems better than the hospital's and the potato chips she brings are better than nothing. As the child's condition improves, so does his appetite. It is a joy to see him look forward to a meal. Then we face the problem of reestablishing good eating habits.

When he feels unwell, the child is lethargic and tires easily. He sleeps long periods and tends to be quiet and passive. Frequently he is irritable, whiney, and demanding. He regresses under the stress of hospitalization and illness. Such behavior can carry over into periods of remission when the child feels well.

Adults tend to overprotect and overindulge the child with a fatal disease. The child, confused by the sudden change in his parents' discipline, may learn that he can use his illness to manipulate them and satisfy his whims. He may become so spoiled that sick or well he is unpleasant to live with.

The nurses have to adapt their expectations to the child's condition. We have to accept his lethargy and plan long rest periods. We expect dependence and self-concern. We try, however, to treat the child as normally as possible and encourage his parents to do the same. Misbehaving produces a reprimand, as we have a stake in preserving the pleasant, well-disciplined behavior the child had before he developed leukemia. If we help spoil him, we will have to live with him. If we can help the family to treat him normally, we may avoid some of his confusion and fear and reduce the resentment other members of the family feel toward him.



Play must also be adapted to the child's condition. When he feels ill, he wants only quiet, passive amusement. He may watch television and like to have stories read, or he may color, paint, and play with cars or dolls for short periods. A member of the hospital recreation staff comes to the ward each day to conduct playroom periods, and helps children in bed with toys and projects.

The child does not have to go to the playroom. Recreation is one of the few areas of his life he can control. Many of the children have formed close attachments with the "play-lady" and playroom time is one of the happiest periods of the day. Many insist on going even when critically ill; they go on stretchers, intravenouses and all. Often they will play out their hospital experiences, starting intravenouses on dolls, and using plastic syringes to draw up red paint and squirt it into little bottles. When they feel better, the children enjoy more active games, such as riding the ward tricycles.

Appearance may upset child

During the course of the illness, the child's appearance may become grossly distorted. Bleeding leads to huge bruises, packed noses, and caked, oozing lips and gums. Drugs and radiation can cause baldness or loss of hair tone. High doses of steroids produce "moon face" and obesity. Emaciated limbs and protruberant abdomens give an impression of "all knees, elbows, and tummy." These changes upset the parents and the patient. The child worries about his looks and his friends' reactions.

During remission, the child's appearance is usually fairly normal, but during treatment and the terminal stages of the disease, his looks may be dreadfully changed. We do not hide the child because of his appearance, but accept the changes. If he wants to go into the hall,

he may. The children usually accept each other, but we try to make sure no one is teased. Cushingoid changes disappear when steroids are reduced.

We encourage the child about his appearance. Beautiful, thick hair grows back in most cases of hair loss, and in the meantime the Cancer Society can help by providing an attractive wig. We try to emphasize assets by finding pretty dresses for girls without hair and clothes that camouflage large abdomens and cover bruises. If they want to, they are allowed to wear their own clothes.

To provide continuing and consistent care for each child, all members of the nursing staff are involved in our planning for him. Reports include not only physical condition and doctor's orders, but also details of the child's day, his reaction to new medication, his newest toy, and his behavior when his parents visit. A nursing care plan for each child is made at nursing team conferences and is frequently reevaluated to keep it up to date. We keep the plan when the child is discharged so that we can use the same approaches if problems recur during subsequent admissions.

Eventually neither drugs nor medical and nursing care are effective against the disease. During the terminal stages, the child needs highly skilled, gentle, constant nursing care, and must be kept as comfortable as possible. At this time the nurse's thorough knowledge of the child and his family is most useful. She uses medication liberally to combat pain, and positions the child so that he is comfortable and breathes easily. She tries to prevent hemorrhage and trauma. She provides a calm, quiet environment so that the child can rest as much as possible, but she also responds to any sign of interest in activity or to expressions of fear. She maintains the intravenous so that blood and drugs can be administered promptly and easily. As comforter and protector, she attempts to make the child's death as painless, fearless, and peaceful as lies within her skill.

Family fears

Even when leukemia has been suspected or feared, confirmation of the diagnosis is a terrible blow to the parents. During the first admission, great adjustments must be made. Parents need time to accept the diagnosis; they need to change their lives to cope with a fatally ill child and his hospitalization. They may feel ill at ease with their child because of his disease and have trouble relating to him. On the other hand, they may shower him with expensive toys and treats.

The parents dread the effects of the illness. They may be so upset that they cry when they visit or leave, or they may react with hostility toward the hospital, the doctors, or the nurses. Each visit to the doctor or the hospital renews fears that death may be near. When the child is in remission, it is hard to believe that this healthy, apparently normal child has a fatal illness. The parents learn to look for bleeding, fever, pain, vomiting, and lethargy. They see the suffering of other children on the ward and fear for their child.

The family lives through a prolonged period of stress aggravated by periodic crises. The mother is usually closest to the child and bears the brunt of the illness. Her other children may resent the time she devotes to the child with leukemia. The father may resent the concern that is diverted from him to the child, and the mother may feel that no one understands her problems or gives her enough support. Conflicts already present in a marriage may be aggravated to the breaking point, although many families draw much closer together. Well-meaning relatives and friends can provide great emotional and practical assistance, but they can also magnify fears and accentuate the difficulties by prying or offering misleading advice or news of cures for leukemia.

Sometimes parents feel great guilt. They may interpret the child's disease as punishment for their own misdeeds, or may feel they are not doing enough for



the sick child. They may worry about disruption to work and normal family and social life. Also, parents may feel guilty for agreeing to submit the child to unpleasant, painful procedures, or for wishing that death will come soon to release their child from suffering.

To establish a relationship of cooperation, support, and trust with the parents, the nurse must be available to talk to them and provide an outlet for their feelings. She must accept their worries, hostility, or unrealistic hopes, and be honest with them at all times. She answers the questions she can and refers questions she cannot answer to doctors. She keeps the parents informed of the child's condition on such details as how he ate and slept, how he reacted to their departure, or when a procedure will be done.

If there are severe family or financial difficulties, she makes sure the parents are referred to psychiatrists, medical social workers, clergymen, or groups such as the Cancer Society to alleviate the problem before the family reaches the breaking point.

We encourage the parents to help with the child's care. They change diapers, give

bedpans, take temperatures, help with mouth care, bathing, changing linen, and maintaining special routines and bedtime habits. Frequently Mummy can persuade the child to take food or medication he would otherwise refuse. Parents provide the supervision toddlers need and help the children with play. Helping with the child's care brings the parents closer to him and overcomes their feeling of strangeness. They become closely involved in their child's hospital life.

When the child is dying, the parents usually want to be near. The nurse must consider their needs and show both the child and parents that they are not abandoned. A rollaway bed or chaise-lounge can be set up in the child's room. The facilities are unfortunately suitable only for short stays. We discourage parents from staying for long periods because a tired parent is under even greater emotional strain. The nurse assigned to the terminally ill child must include his parents in her care. She must talk with them during long periods of waiting and worrying when they face difficult questions, grief, fear, and doubt. She has to consider their physical comfort and provide as calm and restful an environment for them as she can. By remembering their need for sleep and food, she can help the parents spend time away from the child when he is sedated or sleeping.

As the child slips into unconsciousness and death, it is the parents who concern her most. When the child dies, a nurse who knows the parents takes them to a quiet room, provides coffee, and gives them an opportunity to express their sorrow while others prepare the body so that they may see their child again if they wish. Everything possible is done to prevent further worries before they leave hospital.

Facing death

It is difficult to work with children who will die, knowing leukemia deprives them of normal experiences. Death from an incurable illness may seem to mean failure, but it is often a release from intense suffering.

The child with leukemia presents great opportunities for skilled, concerned nursing care. With these children, we concentrate on the present; today's problems and joys become our main concerns. Today we are happy to see him show interest in a new toy, walk for the first time in weeks, spend a comfortable night, or go home in remission. Today he needs mouth and skin care, analgesia, or someone to hold him because he is homesick. We cannot deny the child's prognosis, but we do not have to dwell on it.

The child who asks about death and his disease is a source of anxiety to the nurse who is often afraid to discuss death with him. Frequently it is the nurse the older child will approach. He may simply mention death as all children do at times, but he may be seeking help which the nurse may fear she cannot provide. We try to anticipate when a child is likely to ask about death, for example, at the time of another's death. We may discuss how to deal with the child's questions and fears with parents and doctors. Often, however, the nurse is left to rely on her own skill and judgement in talking with and helping a child who knows or guesses he will die.

Although we are concerned about each patient, over-involvement with one child is a problem we must try to avoid in caring for fatally ill children over long periods of time. The nurse whose concern for a child becomes too personal can be deeply hurt and unable to be objective enough to give professional help to the child, his parents, or the other children on the ward. Caring for less seriously ill patients on the ward gives the nurse relief from long periods of looking after dying children and a chance to regain a more normal perspective.

Nursing a dying child is a great emotional strain. Each nurse must come to a personal reconciliation with death, but the nurses support one another. The whole ward staff shares the nurse's concern for her patient and spends time helping her to plan and give care, relieves her for breaks and meals, and gives her a chance to express her feelings. We share the experience so that no one is overwhelmed.

Working on a leukemia ward has many compensations. The patients do not know they are different or tragic. We have a chance to know them well and help their families throughout the course of a serious illness. We are involved in medical research projects that one day may produce a cure for leukemia. Nursing's oldest skills are those of providing help for the sick and comfort for the dying. The challenge of renewing and perfecting these skills leaves little time for depression. □

Collecting urine specimens from children

Description of a method used at The Hospital for Sick Children in Toronto for collecting quantitative urine specimens.

Eleanor G. Pask

The collection of 24-hours urine specimens is important in the investigation, diagnosis, and treatment of an increasing number of children's diseases. At The Hospital for Sick Children, Toronto, the 12-bed clinical investigation unit (CIU) is designed to admit patients of all ages from the young infant to the adolescent. Various methods of collecting urine are employed on this unit, depending on the child's age and capability.

The child is encouraged to feel that he is part of the team responsible for his care. His responsibilities – which depend on his age – are explained to him, and as much time as necessary is spent helping him understand his disease and the investigations he will have. By encouraging his participation in his investigations we gain his cooperation. The more he understands, the more he wants to help.

Often, a trial run of 24 hours is found helpful before actually starting the collection. During this time the child learns about his new responsibilities. At no time is he allowed bathroom privileges, hence his activities and routines change little when collections begin. An accurate urinary output is recorded daily on each child so that when the time comes to collect urine, he is used to the method. Often he is taken to the laboratory to meet the technician and to see where his specimens are sent.

The staff, nurses, doctors, dieticians and technicians, work closely with the children at all times. Children tend to copy the attitudes and meticulous attention to measurement and timing displayed by those who care for them.

Timing

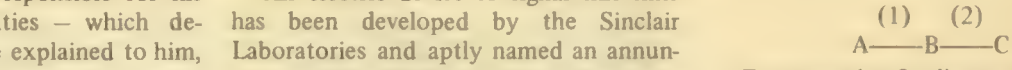
The timing of urine collections must be accurate. In the past, a nurse had to sit by the untrained child and wait for him to void. Thus she established the precise time at which the 24-hour period began.

An electric device to signal this time has been developed by the Sinclair Laboratories and aptly named an annunciator. As the child voids, the urine comes in contact with the ends of water sensitive leads, thereby setting up an electric current that activates a buzzer, which does not stop until it is turned off by hand.

The beginning of the collection occurs at the exact time of voiding. This urine is discarded, the bladder is then empty, and all subsequent voidings are added to the collection. The final voiding is added and the time is recorded as the ending time of the collection. Again the bladder is empty.

The ending time may not occur at exactly 24 hours after the beginning. However, it is important to remember that the collection ends at the precise time of voiding, even though it may be shorter than the 24-hour period. All urine from the initial emptying of the bladder until the final voiding constitutes a complete collection.

If another urine collection is to commence when this one is completed, the final ending time for the first collection becomes, as well, the beginning time for the second collection.



For example, if collection (1) begins at A and ends at B, the collection (2) begins at B and ends at C. In this way no time is lost and specimens are consecutive. This method is used for shorter periods of collections, such as clearances or consecutive 24-hour collections. During a collection, all losses are recorded. It is best to check with the laboratory doing the test to determine whether or not it is feasible to continue, or better to start another collection.

Procedure for female infants

It is advisable to have two nurses available to place a child on the urine collection frame and apply the collector correctly. The female infant is placed on a Bradford frame with an aperture under the buttocks. The canvas frame is covered with a one-inch layer of foam rubber

Mrs. Pask, a graduate of the Hospital for Sick Children, Toronto is head nurse in the clinical investigation unit at the Hospital for Sick Children.

An electric annunciator, shown with the water sensitive lead and adaptor.



which is, in turn, covered with thin plastic sheeting. The edges and seams of the plastic are sealed with waterproof tape. A cotton sheet with Velcro tapes (Canadian Velcro Limited) is placed over the whole frame. The infant appears comfortable, and skin problems arising from areas rubbing against the frame are minimal. A jacket restraint keeps the upper portion of her body still. Her legs are abducted and restrained in a frog-like position.

The collector is made of thin but slightly pliable polyethylene and is attached with soft plastic to a 150 cm. length of plastic tubing. The tubing with an added adapter fits into the collection bottle. The bottle is surrounded by ice in a double-chambered, stainless steel holder that hangs on the end of the bed. The collector comes in three sizes: No. 1 fits an infant up to about six months; No. 2 fits up to two years; and No. 3 up to four years.

A small air vent at the top of the collector assists in drainage of the urine. We insert a No. 25 needle into the tubing near the collector and tape it in place to allow more air to enter the system. This prevents back-up into the collector and avoids overflow.

The skin is cleansed with a Betadyne solution (British Drug Houses) and dried thoroughly. The area that will be in contact with the collector is then sprayed with Dow Corning Medical Adhesive Type B, an aerosol contact cement. The broad rim of the collector is also sprayed, and when the adhesive becomes tacky in both areas the collector is applied by gently placing the lower end against the perineum and cautiously pressing it upwards.

As this is done, the labia majora are separated so that the broad sides of the collector rest against the inner aspect of the labia majora. The collector is held gently but firmly in place for a minute or so. Although the appliance is now secure, it is wise to add four strips of one-half inch Elastoplast (Smith & Nephew) to prevent the collector from coming loose as the child moves about or defecates.

A collector applied in this manner should be secure for three or four days. At this time, even if it appears to be well attached, it should be removed and, after a thorough cleansing of the area, a new collector applied. Reuse is not practical since soaking or autoclaving softens the plastic.

A 2" x 16" x 11" pyrex or stainless steel tray, covered with Saran Wrap (Dow Chemical of Canada Ltd.) is placed on the bed under the aperture so that any loss of urine or leakage from the collector will be caught and can be syringed from the Saran and added to the collection. If the collector leaks, it should be reapplied rather than re-taped.

A blanket pinned at top and bottom covers the patient from the waist down. This not only adds to her feeling of security and comfort, but also prevents her from pulling the collector off.

Procedure for male infants

The same frame is used for male infants, but it is unnecessary to restrain them so firmly. The use of Sterilon 24-hour Pediatric Urine Collectors has proven satisfactory. The skin is prepared the same way as for female infants. Although the collector has an adhesive surface, the addition of aerosol cement greatly improves its efficiency and holds it in place longer.

Occasionally the adhesive tape or cement may irritate the child's skin under either the male or female collector. Discontinuing the collection temporarily, allows the area to heal quickly.



Female urine collectors, sizes 1, 2, and 3.

The male collectors are much less restricting than those used for girls. The male infant can be placed in a sitting position, whereas the female can be only slightly propped.

This method of urine collection can be modified to facilitate stool collections from children with profuse diarrhea. Stool is collected in a plastic bag taped to the aperture. About one inch of the margin left at the front of the aperture allows the tubing from the urine collector to pass through to the bottle. In this way uncontaminated stool and urine can be obtained.

Nursing care

Generally, children are kept on the frame for about 4 days. The longest period we kept a baby girl on the frame was for 16 days. During that time she seemed comfortable and secure and suffered no apparent physical or emotional trauma.

Children restrained on the frame during urine collections need more direct physical nursing care and emotional support than children who are up. We spend much time with these children, reading and playing to keep them occupied and happy. We consider this diversional care to be a major nursing responsibility.

When they are on the frame girls wear dresses and boys wear shirts. This helps to keep up their morale and they accept collections as a routine part of their investigation.

These children enjoy the frequent visits and attention of other children on the ward. Parents are encouraged to visit. We inform parents a day ahead about the methods that will be used to collect urine, so they will be able to give their child the extra care and attention he will require during their visit.

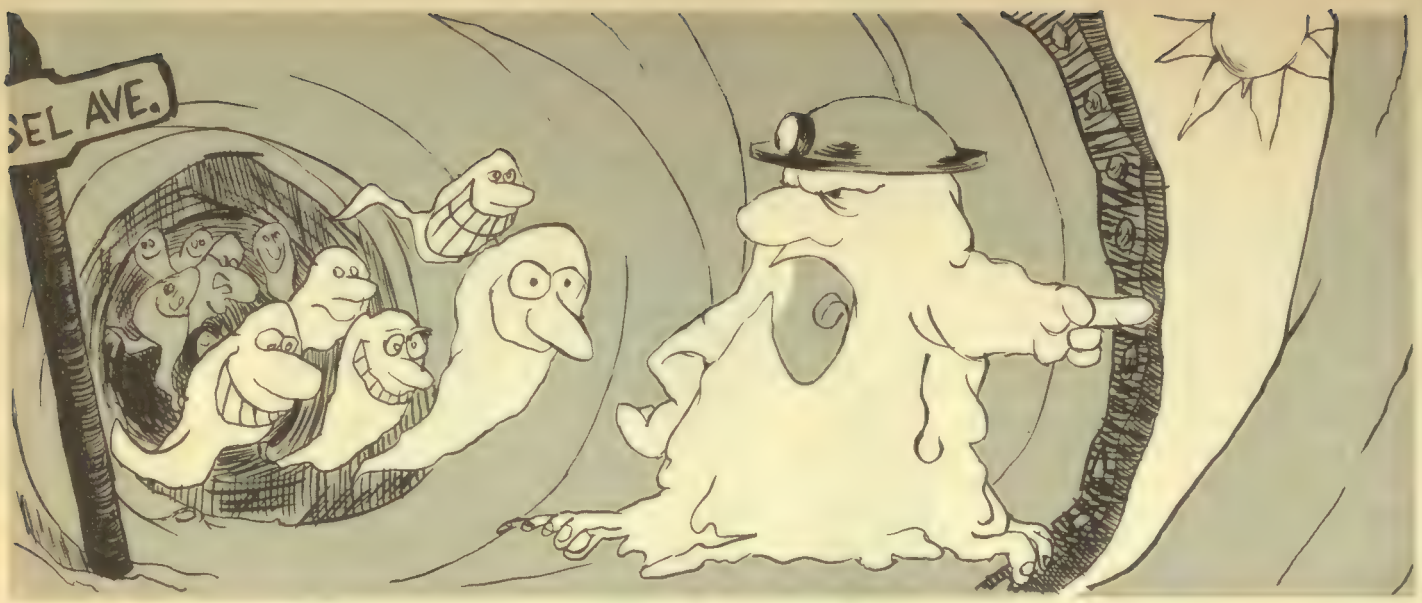
The amount the child eats during his period of collection is important since frequently the results of his biochemical tests are dependent on a constant calculated intake. Every effort is made to encourage the child to eat everything put before him. At meal-time, children on frames are in the same room with other children in the unit so they can enjoy each other's company. □



A female infant having a urine collection, showing the equipment described in this article and its proper application.

Correct application of the female collector, with the addition of four elastoplast strips to increase its efficiency.





The coagulation of Harry

A novel approach to the blood clotting process.

Terry Lynn Carter

Once upon a time, there was a bloody little fluid named Harry. He was a very complicated little fluid, consisting of plasma, in which he carried red and white corpuscles, platelets, and fat globules. Altogether he was 22 percent solids and 78 percent water.

Many times every day he chugged merrily through the heart, arteries, veins, and capillaries of the human he served. He took pride in his job. The only part he disliked was crawling through the capillaries. Some of those tubes were so small that he had to hold his breath to squeeze through; but every job has some drawbacks.

Harry's main duties consisted of chugging through the maze of tubes in the body, carrying nourishment and oxygen to the tissues and taking away waste matter and carbon dioxide. It was a routine and rather dull job, but Harry pushed on, knowing deep within his little bloody fluid, that someone had to do it.

Harry was chugging along as usual one day when suddenly it happened. Up ahead on Finger Vessel Avenue, disaster had struck. Something sharp and shiny had cut the route in two. Harry activated his alarm system and started to organize his defense. The vessel around him had already started to contract.

A liquid of strength, Harry whistled for his first team of action, the platelets, to go to work. Running from every direction, the platelets started to agglutinate or clump together. They huddled together, and on Harry's order released serotonin to stimulate further vessel contraction.

Harry took a deep breath as he moved into phase two of his defense. He summoned fibrin to the scene of the accident. Fibrin responded quickly – protein fibers formed a meshwork to trap more platelets and red blood cells. A clot began to form, filling the whole vessel diameter; the vessel then began to retract.

The clotting process had begun when prothrombin activator was formed in response to the ruptured vessel. Then prothrombin activator converted prothrombin into thrombin. Next, the enzyme thrombin converted fibrinogen into fibrin threads to enmesh red blood cells and form the clot.

But Harry wasn't interested in such details. He had a fight on his hands; facts could be left for historians to write about. He looked over the scene with pride. "Men at Work" signs were posted and emergency lights flashed as platelets, fibrin, and the clot worked furiously to repair the vessel. Platelets sent out processes and fibrin threads. Harry watched as the processes contracted, pulled on the threads, and made the clot even smaller. "Not bad," he thought.

A siren screamed and macrophages raced to the scene to invade the clot and to phagocytize the red blood cells. After gobbling up the debris, the macrophages released hemoglobin into the tissues.

Working through the night and into the next day, Harry and his little crew of emergency workers repaired the damage. What remained of the clot was invaded by fibroblasts that produced collagen and elastin to turn the clot into a fibrous mass. Under enzyme influence, this fibrous mass was replaced by connective tissue. New blood channels formed through the clot and after recanalization took place, Harry returned to his job.

He chugged through the new channels with glee, wondering what his human had been doing during the disaster. "Probably putting on a Band-Aid," he thought. If only he knew all that had taken place!

The disaster signs came down and the emergency team resumed its normal duties. Harry filed his report and returned to his job, wistfully recalling the excitement that had gone before.

He spit out the carbon dioxide and chugged oxygen and nourishment to the tissues. It was dull, but if he got too fed up, he could always donate himself to the Red Cross; anyway, he was up for retirement soon.

So, Harry, the bloody little fluid, chugged on, doing his dull routine job, knowing as his liquid filled with pride, that he had had his day. □

Miss Carter is a second year student at York Regional School of Nursing, Willowdale, Ontario.

How to prolong a hospital's lifespan

The architect responsible for designing the Health Sciences Centre at Hamilton's McMaster University discusses some of the concepts that have applied to this new complex.

Eberhard H. Zeidler, Dipl. Ing., F.R.A.I.C.

The medical professions have extended the lifespan of man, but their ever-accelerating progress has produced a creeping disease that reduces the lifespan of hospitals. The name of the killer is obsolescence.

Today, hospitals have to decide whether to operate in outdated facilities that inhibit medical progress, or to abandon them. If we consider that over a period of three years hospital operational costs may equal capital costs, we may reach the conclusion that the only solution is to demolish these outdated facilities. Yet what a waste of resources!

The specialized spaces that we have to build for a hospital should be used for at least 30 to 60 years to amortize its cost. Yet we know that the function of this space may change several times during its lifespan. Present methods of providing for this change retain little of the original investment.

To demolish outdated facilities seems like pulling up a whole plant, roots and all, to pick one flower. We believed that if we could develop a system that would allow us to cut flowers on the plant, we would solve this dilemma. In such a system we had to distinguish those elements that belonged to the flower from those that belonged to the plant. We called the flower the "non-permanent" parts of the building that would be lost with each functional change of the space; we called the plant the "permanent" elements that would remain as a permanent receptacle.

The "Servo System" became this permanent frame. It is an integration of the structure with the primary electrical and mechanical services, that is, heating, plumbing, and air conditioning, forming a frame into which the various space uses may be "plugged in." None of the elements of this "Servo System" will change even if the non-permanent elements change. Such a system affords the maximum retention of the original building investment, regardless of the changes that must be made to the building during its lifespan. We used this system in designing the Health Sciences Centre at McMaster University.

Because this building is unlike any that has preceded it, it will not have the familiar look of a hospital, a school, or a research institute. Instead, it will express the unique qualities of its structural-mechanical system, the "Servo System," and the unpredictable nature of its functions. Thus the exterior shell of a nursing unit may look the same as a research laboratory because the function of the space is interchangeable.

The Servo Shafts punctuate the facade, expressing in their glassy transparency their structural and mechanical purposes. Spanning between them are the great trusses clad in simple, unadorned panels sandwiching each habitable floor. A pattern of separate window and wall units express in their forms and in their random distribution the ability of functional freedom.

Mr. Zeidler is an Architect with the firm of Craig, Zeidler & Strong, Toronto.

Nursing unit

Is there really a need to have all elements of the Health Centre framed in one system? Would it not simplify our design problem to treat the nursing units as separate entities divorced from the other components of the complex? In such a structure we certainly would fulfill all present requirements of the inpatient unit.

We were aware, however, that present needs might not suit future needs, that our approach to health care might undergo principle changes, and that some of them would affect the inpatient unit. Furthermore, it is possible that future reorganization of the Health Centre could make it advisable to replace the inpatient function with another function. In some of the centers we visited, this had happened.

We felt, then, that if we could use the space frame throughout the structure, including the inpatient unit, we would gain future flexibility for the total complex without loss of economy. Looking at



View of Health Sciences Centre at McMaster University in Hamilton, Ontario.

the present trend of development in other nursing units, we found that in layout and organization these units were totally administrative-oriented. Development was geared toward better material handling and better nursing organization, yet the basic reason for the hospital's existence – the patient and his human needs – seemed to be neglected.

In the design of most nursing units, the pendulum has swung from the Florence Nightingale ward to the impersonal isolation of a hotel corridor. This design has created physical barriers that make nursing care difficult. North America has succumbed to the double corridor plan, with privacy considered to be the main requirement of a patient.

When intensive nursing care was needed and the double corridor system made this impossible, the intensive care unit was developed which, in fact, was the old Florence Nightingale ward revisited. This probably explains the higher percentage of ICU beds in a North American hospital compared to a British hospital. The ICU, by removing the barriers, created again the all-important physical relationship between nurse and patient.

At present, North America is developing the physical separation of nurse and patient even further. The isolation of the patient in secluded single rooms is hoped to be solved by science fiction television monitoring and the expansion of the intensive care unit. These remedies destroy even more the nursing incentive of the normal ward.

We believe that an inpatient unit must be patient-oriented. This result will be achieved only if major changes are made in the physical environment of the unit and changes occur in the medical and nursing approach to the patient.

We found three major relationships that had to be balanced in this inpatient unit. At first glance the requirements of each seem to be contradictory to the other. These are: 1. the relationship between patient and nurse; 2. the relationship of the nurse to her team; and 3. the flexibility of the number of beds assigned to each team.

The first relationship – nurse to patient – is, of course, most ideally solved by a direct physical and visual relation of a nurse to a patient, as with a private nurse, or a restricted number of patients in an intensive care unit.

The second relationship, that of the nurse to her team, would require a totally different physical setup, which would remove the nurse from the bedside, at least far enough that a large enough number of nurses could be in a common location to work and be controlled as a team. The team concept is a hierarchical working order. Since the number in the team fluctuates during the three shifts, it would appear advisable to move the nurses' control and chart area further from the bed.

Viewed from the concept of centralized administration, it would also seem preferable to combine in an 80-bed unit



Model of Nurse Work Territory encompassing 18 beds. This picture shows four additional beds that belong to the adjacent team, both forming the 36-bed unit. The Nurse Work Area is in the geographic center of the territory, limiting the furthest point from the Nurse Work Area to 36 feet. The center core contains the teaching spaces.

all these stations under one floor supervisor. The actual experience of these nurses' administration areas has found this centralization less than satisfactory.

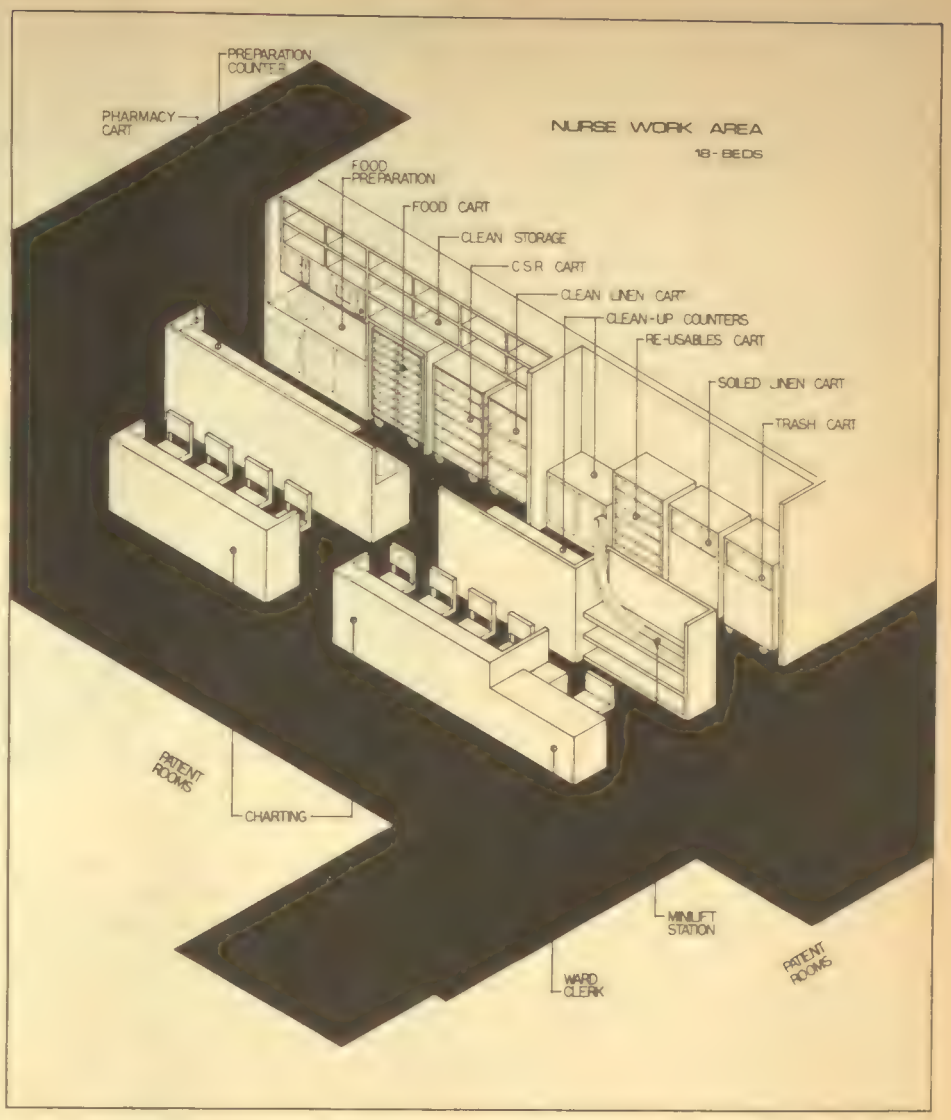
The third relationship is the flexibility of the nursing team and the related beds. This is mainly a demand for economy in services. It is obvious that during his stay in a unit a patient will require varying degrees of attention from the nurse, so that the number of patients a team can look after will change. The double corridor scheme seems to fulfill this requirement. Yet the result of this administrative demand may be a 200-foot institutional corridor, to which neither the nurse nor the patient can relate.

If we accept the team as a working unit, then it is important to relate this to a territory in which a personal relation between nurse and patient can develop. This visual enclosure of the team territory still could maintain an administrative flexibility, as the changing of the number of nurses belonging to a team related to a fixed bedcount would do the same as a fixed team relation to a variable bedcount.

Teaching facilities also had to be considered when we were planning this hospital. A large number of students will eventually be in the unit, and sufficient space had to be created for their movements in small groups without interference with the nurses in service. To provide conference areas for these students too far away from the bedside would turn the corridor into the conference area and create traffic problems for the proper working of the unit.

The construction method chosen allowed us to change and reevaluate our nursing units over the last 18 months, while construction proceeded unhampered. Certain principles have been crystallized and formed our nursing unit.

- The minimum bedroom size should be increased in a teaching hospital for the additional monitoring equipment and teaching space needed to allow groups to enter a bedroom.
- A proportion of one-third of the beds in singles and two-thirds in two or convertible to four-bed rooms is advisable to maintain a balance between economy and changing requirements.
- The organization of the nursing unit should be set at a 36-bed level with the head nurse related to two teams of 18. The next organizational level would be the total hospital without any other intermediate level, at 72 beds.
- The flexibility of the staff-bed ratio could be obtained by movement of staff rather than bed territory.
- A visual relation between nurse and patient should be obtained so that it can be broken if desired for patient privacy. We realized that the motivation of the nurse is made greater through a direct patient relationship than from a constant nursing supervisor control.
- A nurse walking territory of approximately 35 feet is ideal.
- The nurse-server allocated for one or two beds should be replaced by a team supply cart serving 18 beds, thus eliminating additional movements and allowing materials to be handled more economically.
- A definite territorial and visual definition should be achieved for the nursing team.
- A corridor articulation for student "hesitation spots" should also be provided.
- A flexible conference area should be formed in the center of the nursing unit to eliminate undesirable corridor teaching.



Summary

We are only now at the threshold of understanding the relation of physical environment to psychological reaction. The works of anthropologists and social scientists have improved our understanding of this relationship and have helped us realize that emotional reaction toward an environment has a deeper meaning than we used to think.

A hospital must provide an environment for meeting human needs – physical, psychological, esthetic and intellectual. The best of physical care cannot properly succeed if the patient lapses into apathy brought on by monotonous surroundings and a physical plant that recognizes efficiency as its only aim. Attention to emotional and perceptual needs must not be a hastily improvised afterthought. In the planning of the McMaster University Health Sciences Centre, these concepts are vital parts of a totally coordinated complex. □

Hospital design is a nursing affair

Too often the person who knows most about health care facilities and how they help or hinder the delivery of patient care is ignored when such facilities are being planned. Not at McMaster University, however. The author, a registered nurse, has worked closely with the architect and medical staff in the overall planning and design of the new Health Sciences Centre.

Norma A. Wylie, M.Sc.N.

At McMaster University, nursing has had its say in the planning of the new Health Sciences Centre. This participation began early, when the newly appointed executive director of the University Hospital arranged for the director of nursing to join the organization at the same time as himself. Since then, I, as director of nursing, have been involved in all phases of planning, working closely with administrators, members of the faculty of nursing, medical staff, and architects.

Hospital acts as pivot

The three principal objectives of the Health Sciences Centre are delivery of health care, teaching, and research. The University Hospital will become the pivot around which these objectives revolve and will be an integral part of the social and medical organization. Its function will be to provide complete health care, both curative and preventive. The outpatient services will reach out to the family and the community. The hospital will also be a center for the teaching of health workers, and for bio-social research.

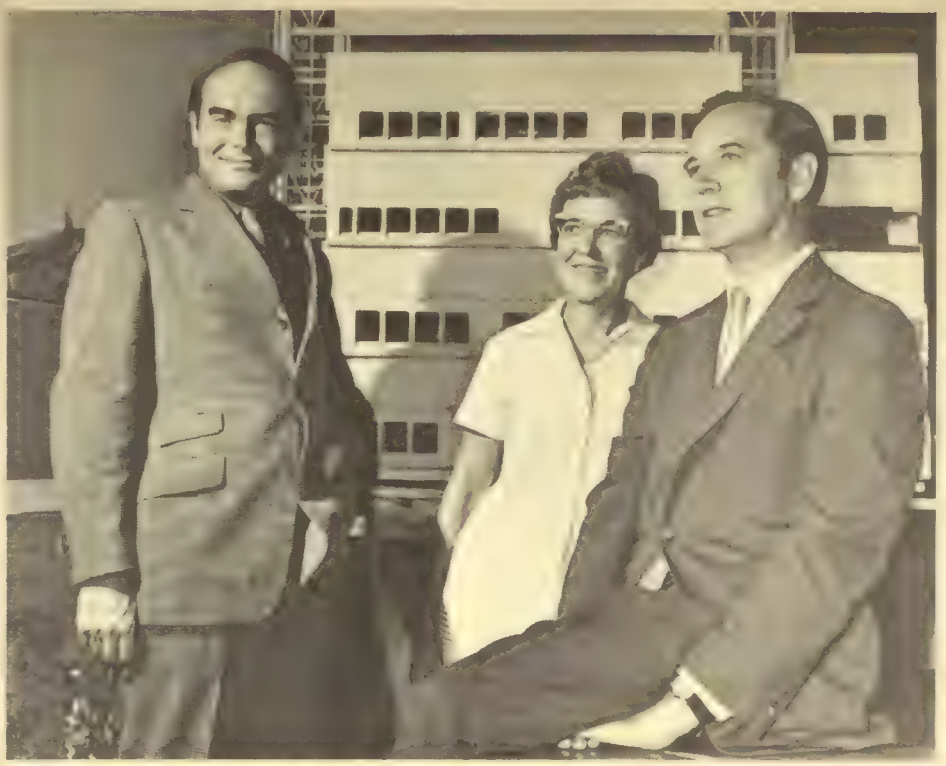
Before attempting to design the complex, the architects wanted to learn about the objectives and needs for patient care and student teaching. Consequently, they met with the principal users of each special area. I was present at most of these meetings. The conversations were recorded and the analyzed data formed the basis for the initial drawings.

The design was also influenced by the demands of our community. We believed we could not plan in isolation from the society in which we live, and that our planning should reflect its aspirations, technological abilities, and economic needs. Thus, regional planning has evolved which has influenced our final plans. The nurses in the community have made a valuable contribution as resource personnel in the clinical areas.

Early discussions with our architects focused on the human needs of the patient – physical, psychological, esthetic, and intellectual. We spoke about the danger of progressive depersonalization of patients and, concomitantly, of nurses, as a result of increasing technical and scientific knowledge. We discussed with the architects the demands that automation places on nurses to acquire new knowledge and develop new mechanical, administrative, and human relationship skills. The means by which

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Miss Wylie, a graduate of the City Hospital School of Nursing, Saskatoon, the University of Toronto, University of British Columbia, and the University of California, was appointed Director of Nursing at the University Hospital, McMaster University in Hamilton, Ontario in January, 1968 and Associate Professor, McMaster University School of Nursing. Prior to moving to Hamilton, Miss Wylie was with the World Health Organization for eight years, first in Singapore and later in Malaya.



Key personnel involved in design of University Hospital: left to right: E.H. Zeidler, architect; Norma A. Wylie, director of nursing; R.C. Walker, executive director.

these skills may be acquired formed a basis for dialogue between our two groups.

The architects and I visited several hospitals to study their physical facilities and to talk with patients and staff. Our findings resulted in a patient-oriented unit as opposed to the traditional administrative-oriented one. Our nursing unit is planned to provide the environment for a close nurse/patient relationship, which should facilitate good quality nursing care and effective learning opportunities for the students.

Patient care hours increased

The involvement of the nurse as a permanent member of the planning team has many advantages. She can help to interpret to the architects the daily activities within patient care areas, and how the relationship of supplies to patient rooms can affect the efficiency of the nursing unit. The principles that have been applied to our nursing units are described by the architect in the preceding article.

This design, combined with a reallocation of many tasks traditionally performed by the nurse, should permit the professional nurse to spend more time in direct patient care, and less in ancillary routines. The knowledge and experience of nurses in our community helped us develop a most efficient materials handling system. This should minimize movement within the patient care area, and increase patient care hours.

The quantity and quality of patient care are directly affected by the efficiency of the hospital's communication processes. Seeing, hearing, speaking, writing, doing, are means of communication whose effectiveness is dependent upon the architectural model.

As director of nursing, I was responsible for assisting in the development of a communications model. This consisted of defining the philosophy and objectives of the communication system in every area throughout the Health Sciences Centre, and analyzing needs withough reference to equipment. My research was done in collaboration with each of the principal users, and I obtained considerable information by visiting a number of hospitals and talking with patients and staff. My findings were submitted to the architects for consideration by their electrical engineers.

Specialized areas

Because of limited knowledge and lack of resources, in-depth research has been needed in some of the highly specialized areas. One such area is our neonatal, obstetrical unit. Visits to specialized units with the architects gave us the opportunity to study the environment and patient needs as to staffing requirements, equipment, and essential services. It also permitted us to observe the activities within the unit, and to talk with nurses, perinatologists, and neonatologists who have acquired special skills for the care of the acutely ill infant. These visits, plus meetings with consultants who were invited to attend special planning sessions, enabled the architect to draw a most imaginative design.

The concept of rooming-in, which is in keeping with our philosophy of family-centered care, was also discussed and investigated during field trips. Our nursing unit design was changed as a result of these visits, where we talked with mothers and fathers, nurses and medical staff.

The nursery is situated in close proximity to all patient rooms, which permits rooming-in for any mother who requests it. This also presents a challenge to the nurse to develop special skills in family-centred care. Rooming-in permits the father to participate in the care of his baby early. His special needs, prior to the birth of his child, have been considered in the design of a most attractive fathers' room.

To consider the concept of family-centered care in its totality, some arrangements need to be provided for the children when mother is in hospital. A lounge has been planned outside the nursing unit in which the family can visit.

Therapeutic effect of environment

Studies have indicated that the architectural environment evokes emotional and psychological responses and has important therapeutic potential. We made numerous visits to study the design, in both old and new hospitals, with particular reference to the effects on the patient.

Our pediatric areas have been especially affected by these visits. We observed the therapeutic effect of murals on the walls and ceilings, of large play areas, of a children's zoo, and special furniture and toys. Studies conducted locally reaffirmed our plan to provide facilities for mothers who wish to stay with and care for their children.

Continuity of care is one of our primary goals in planning the delivery of health care. We recognized early that the

design would greatly affect our ability to meet this goal.

In recent years, the center of gravity of a hospital has shifted more and more from inpatient to outpatient departments. The outpatient area is the point of contact between hospital and community, and the patient's first impression of the hospital may be gained here. This department has been appropriately described as the hospital's "shop window." Its layout, furnishings, and decor can affect both patients and staff.

Continuity of care has been further enhanced by designing the inpatient services, teaching facilities, and outpatient services of each department in close proximity, horizontally to each other.

The organization of the hospital's administrative setup affects design. Within the organizational plan for hospital administration is the department of nursing. We believe that the senior nursing members, to be called assistant directors, should be where the action is. These assistant directors will be responsible for implementing the continuity of care, discussed earlier, between inpatient and outpatient department. Thus, their offices will be in an area closely related to their major clinical responsibilities. In close proximity to them will be offices for the clinical nurse specialists. This arrangement of the home base office for the senior nursing staff should provide maximum opportunity for exchange with all members of the health care team.

Each nursing unit will have a patient lounge to provide a therapeutic milieu for nurse/patient/family/doctor interaction. The situation of this lounge is important. We have emphasized to our architects that it is best placed within the heart of the nursing unit to permit maximum opportunity for the nurse to observe her patients and their visitors, so that she can give appropriate care when indicated. This site will also be used for patient teaching by members of the health team.

In planning the unit design, we kept the family and its needs in strong perspective. A dying patient, or a sudden tragedy, require skillful understanding. Often the nurse is the one who is present to communicate with the family. We discussed with the architects these matters of life and death, and encouraged them to explore the effect of environment and the need for privacy during difficult times.

Small quiet rooms have been designed adjacent to the nursing units where relatives may retreat or be joined by the clergy or staff member, if requested. Also, a special family room adjoins the intensive care unit where relatives may come and go as desired. An interdenominational chapel, with offices for the chaplains adjoining, is situated near the special family room.

Teaching facilities

One of the primary objectives of the planned Health Sciences Centre is to provide teaching facilities that will create an environment for learning. Conference rooms are located in each unit immediately adjacent to patient accommodation. This will allow students to pursue discussions in small, medium, or large groups, appropriately removed from patients and families.

Collaboration with members of the university's faculty of nursing during the planning of the nursing unit has enhanced the design of the laboratory to which students come for clinical learning and experience. Because the director of nursing of the University Hospital is a member of the nursing faculty and of the curriculum committee, a fair amount of understanding has developed of both patient care and student needs. The establishment of these relationships between nursing service and nursing education at an early stage is vital for the success of good quality patient care and student education.

Research

Research is the third objective in planning the design for the Health Sciences Centre. Stress is being placed on the expansion of nursing knowledge through research and the translation of the findings into improved health care. A project is presently being conceived to study new areas of nursing activities and responsibilities to utilize the nurses' skills more effectively. This study is specifically related to the role of the nurse practitioner and is being conducted in a family practice clinic in an affiliate hospital.

A nurse practitioner who has demonstrated special skills and knowledge related to family care was appointed in September, 1968 as director of the project. I have been actively involved as a member of this project committee. The findings and deductions will be utilized to determine patterns of staffing and differentiation of skills in the organization of the family practice unit, which will be an integral part of the University Hospital.

More experimentation with staffing patterns and the effect of design – in inpatient and outpatient units – on quality of care needs to be done. Because we have been committed to much innovation in this project, a great deal of research and evaluation must be carried out to corroborate the value of such a design.

The wisdom, experience, knowledge, and intuitive insight of many minds has purposefully guided the planning for the Health Sciences Centre. I have appreciated the privilege of being a member of the planning team and being able to initiate the involvement of nursing in all areas. It has given us an opportunity to establish good working relationships with representatives of many disciplines – not only in the physical phase of planning, but also in the operational and program aspects for the total project. The Health Sciences Centre will be an excellent vehicle to carry out the delivery of a high level of health care, student teaching, and research. □

Check your image — it's slipping!

In Burns' poem, a fine lady put on glamorous airs, unaware that a wee louse was giving away her true habits. Nurses are claiming — with some good reasons — to be professionals, but their looks give them away.

Glennis Zilm



Professional? Nurses? Well, maybe. But in their identifying uniforms, many look about as professional as a doctor making rounds in his bare feet or a lawyer pleading his case in a bathrobe.

During the past few years, I visited nearly 60 hospitals in six provinces. Almost without exception in these hospitals, many nurses were rumpled, dirty, and frumpy – so many that this untidy and, yes, unsanitary image is the one that stays in the mind.

It is true that clothes do not make the professional. But, being professional implies that one has a pride in oneself and in one's job; usually the professional shows his commitment to his calling by representing it well when on public view.

Being professional, too, implies that the individual polices himself, not that orders come from above. Yet, all too often directors of nursing or supervisors have to issue directives ("No rings." "Uniform skirts must be below the knee.").

Miss Zilm, now a reporter for The Canadian Press, was formerly assistant editor for *The Canadian Nurse*, and before that – obviously – a nursing instructor teaching nursing arts.

● *There is nothing wrong with short skirts – patients like their nurses to look nice. But who would blame the man in the next bed from thinking all sorts of things?*



● *The uniform on the nurse on the right has shrunk. If that good-looking graduate really wanted to look right, she would chuck it out.*

Our patients have a right to expect nurses to be appropriately and professionally dressed – after all, they pay for it. A few years ago nurses may have been able to claim that they could ill afford to buy new shoes or replace a uniform that had shrunk from too many washings. This is no longer true; collective bargaining has raised salaries out of the poverty range. And nurses should realize that they can pay less to look smart in uniforms than teachers or secretaries must pay to provide themselves with chic working wardrobes.

True, administration deserves to share some blame; most hospitals fail to provide adequate change rooms, for one thing. Yet, when bargaining for nurses, how many staff associations demand – or even ask for – large, comfortable change rooms and efficient, effective laundry service? Every day you see purportedly professional health teachers walking into supermarkets on their way home, having spent the day caring for pneumonia patients or changing dressings on draining wounds. If the public understood more about health and knew the story of Typhoid Mary, they would probably label these nurses Pneumonia Patty or Staphylococcus Sally.

This article does not argue that professionals need to avoid short skirts or makeup or fashionable hair styles. Often the most professional-looking nurse on the ward has the shortest skirt, is attractively made-up, and has the latest hair style.

But this nurse has other attributes, too: She is clean. Her uniform fits and she wears pantihose and moves gracefully so that her skirt, though short, does not ride up. Her shoes and stockings are clean and whole – not holey. Her cap is fresh. She owns a clean, washable, white sweater to wear if it is cold on the ward. Her hands and nails look lovely. Naturally, anyone so charming and wise is engaged, but she wears her diamond on a fine chain around her neck to protect it and to protect her patients.

Of course, she is most likely a student nurse – not yet a "professional." As soon as she graduates, she will probably stop fighting the trend to untidiness.

The following photographs illustrate the 10 most common dress faults that nurses make. They were posed by student nurses from the Ottawa Civic Hospital – where, incidentally, I saw fewer untidy nurses than in any other hospital I visited. There, the overall image was of a clean, tidy, and professional health worker. □



● *You do see hair like this on wards. How would you like to be the newly-admitted patient who opens up his fresh hospital bed to find a long black hair on the drawsheet? Or the diabetic who finds one on his tray?*



● *Two faults together here: All nurses have seen shoes and stockings exactly like these – and those are not new runs, either. Surely, for our mental health, we have a better self-image than that!*



● *The most unprofessional look of all – wearing the uniform on the street, in buses, at the beauty parlor, or while shopping for groceries on the way home. A fine health teacher this nurse makes!*



● *She's cuddling all that dirty linen against her uniform; tonight will she cuddle her baby daughter against that same uniform?*



● *Of course it gets cool on the wards on night duty, so what could be nicer and more unprofessional-looking than a woolly red cardigan?*



● *This graduate must be very proud of her cap – she has tossed it onto the top of her locker after work every day for four months. It is stained, battered, and securely anchored with those big, black bobbypins.*

● *She's engaged, she's lovely, she's carrying staphylococci around on her diamond. And yesterday she gouged a huge scratch on a patient's back while changing the drawsheet.*



The nurse and the sociopathic personality

Patients who are sociopathic are skillful in engaging in subtle interactions with those around them. They attempt to undermine others, and may place the staff in situations that endanger their roles.

Anthony M. Marcus, M.A., D. Psych., L.M.S.S.A.

Individual human functioning may be examined by looking at the three interrelating components which, together, comprise personality organization: the psychological, the somatic, and the behavioral. A patient who expresses his symptoms in the psychological, somatic, or psychosomatic spheres invariably complains of some form of internal distress, whether physical or psychological. This patient states that he feels bad, that he feels a pain, that he feels subjectively disturbed in some way. He feels the pain inside himself. He hurts. He is suffering, requires help, and actively seeks it out. When he is a patient on the ward, he is willing to call for help from the nurse.

The nurse responds to this patient who has a definite sick role and approaches him, wrapped in her own mantle of nursing. She approaches him feeling comfortable, knowing that her own role is secure and that she is approaching an individual who has a defined role as patient. Thus, both patient and nurse are reaffirmed in their role assignments and approach each other with minimum anxiety.

This is not the case, however, with the patient who has a sociopathic personality. This patient displays his symptoms in the form of a malignant, behavioral reaction, and does not feel the pain inside. The pain is felt by others. The patient's distress is directed externally on to those who are trying to help him. Instead of the patient suffering, it is the nurse who feels uncomfortable, has a feeling of defeat, is irritable, and somehow extremely frustrated, yet not always aware of the source of these feelings. She leaves the ward at the end of her shift with a headache, with the symptoms of tension, and feeling very confused.

By projecting his anxiety onto others, the sociopathic individual makes them less useful, less adequate to their task, and undermines their self-confidence in their roles. The nurse is made to feel she cannot cope and, as her sense of unease continues, the patient is only too aware of her increasing discomfort and anxiety.

Often these individuals, who are highly sensitive to the nuances of personal interaction with others, exaggerate the situation by taking advantage and manipulating those around them.

One patient encouraged a student nurse by saying, "You know nurse, I have never felt before with anyone the sort of feeling I have that you can really help me. I would really like the opportunity of spending more time with you, because I feel you have the capacity to bring me out of myself." The nurse, flattered that she was being thought of this way and appreciative of the patient's words, spent more time with him and encouraged him.

That night, the patient went to the nurse in charge and said, "I don't want you to say anything, but when Miss Jones gave me a needle, I got the impression that she stabbed me with it a little more harshly than necessary. In fact, this is the second occasion it's happened and I really think she has it in for me. I wouldn't like you to say anything, but I feel this isn't right."

The charge nurse called the student into her office and asked her if something about Mr. Smith upset her to the point where she was unnecessarily or even unconsciously causing him pain. The student, expecting praise for her care of this patient, was more than shattered and left the ward that afternoon with a severe tension headache, her confidence undermined.

These patients, skillfully able as they are to engage in subtle interactions with those around them, constantly attempt to undermine others, to place the nurse in a situation where her role is definitely endangered, and her response is that of increased signals pointing to her own distress. It is therefore extremely important for her to be sensitive to her own subjective feelings when interacting with these patients. The feeling described above will be the ones evoked in the nurse when interacting with a sociopathic personality

Dr. Marcus is Assistant Professor, Department of Psychiatry, and Head, Section of Forensic Psychiatry, The University of British Columbia, Vancouver, B.C.

Sociopathic traits

The following characteristics may help to give a framework which enables the nurse to understand those individuals described as a sociopathic personality.

These individuals often have above average intelligence. They are plausible, may be extremely bold, and have considerable superficial charm. One can usually spot sociopathic individuals in a ward in a mental institution because the student nurses are sitting with them. Their charm and brightness can be captivating.

If a patient confronts the nurse with such drama that she wonders how he can think that way, she is more than likely dealing with a sociopathic personality. Usually this patient has a self-centered callousness and capacity to exploit others.

The frustration tolerance of these patients is low. They are impulsive and ruled more by pleasure than reality; they cannot anticipate, wait, or look forward to things, but need instant gratification. They have a recklessness that may, on occasion, endanger themselves and others.

Sociopathic persons do not profit by experience. They do not appear to suffer the social disgrace of the average law-abiding person appearing before a court of law on a charge.

Whenever there is an opportunity, sociopathic persons form a delinquent subculture. This is an attempt to undermine the program of the system in which they find themselves. It is extremely difficult to manage more than one of these persons in the open ward of a general hospital's psychiatric unit. If, for example, individuals on a ward are receiving or trafficking in narcotics or alcohol, the atmosphere of a therapeutic environment can rapidly deteriorate and chaos result. The nurse must be aware of patient interaction, of the more subtle communications that go on between patients, and of manipulations intended to play off the staff one against the other in order to create a sense of distrust and tension between the staff members.

Why should the sociopathic personality be regarded as a psychiatric disorder? Are not the characteristics of ruthlessness, energy, high intelligence, and charm those necessary for being the president of a large corporation?

The sociopath is chronically engaged in a life style that may result in personal disaster involving imprisonment and often suicidal attempts. These individuals may be termed self-drivers in reverse. Their lives show an inbuilt tragedy and a will to fail. The business man, on the other hand, is goal-directed and intends to stay at the top, whereas the sociopath never seems to be able to carry off the coup with success and rarely escapes to South America to live in luxury on the proceeds of his activities.

It is said the sociopath has no conscience. From my own clinical experience and using a biblical analogy, it is my opinion that self-mutilation or suicidal attempts are examples of self-punishment, that such punishment only occurs when there has been self-conviction of a crime, and this implies guilt and thus the presence of conscience as an ever present but perhaps highly concealed factor in these cases.

Types of sociopath

Sociopathy may coexist with neurotic, psychotic, or borderline psychotic processes, these elements being defined on psychiatric examination. Two major types of sociopathic personality are:

- *The dys-social individual,* such as the criminal narcotic addict, is a member of a delinquent subculture, shows allegiance to it, and conforms to its mores. Belonging to the group and adhering to its value system is important to him. The subculture may have its own methods of communication and even language. It is cohesive and careful with respect to non-members.
- *The anti-social individual* is often restless, furtive, and alienated, showing allegiance to no one and to nothing, and he can be dangerous. Because of his marginality, he may be chronically frustrated, revengeful, and inclined to seek vengeance by harming others.

Interrelating with these two types are sociopathic personalities who may be regarded as *inadequate* in that they maintain a low level of subsistence and show persistent mediocrity in their exploits, social, and vocational goals. The *aggressive* sociopath, while possessing most of the features already described, is inclined to catastrophic, explosive outbursts under minimal stress. Many of this group show electroencephalographic disorders, and treatment with Dilantin is a valuable method of maintenance therapy for them. The *creative* sociopath may have considerable intelligence or artistic talent. In addition, he may possess charismatic qualities that give him considerable leadership potential and powers of persuasion over others. Individuals in this group can play important parts on the world stage; with assistance and good luck, they can become stable and resourceful people.

It is important that the nurse learn to use herself as a therapeutic instrument so that in her encounters with her patients she acts as an emotional barometer, permitting herself to feel the effects the patient may have on her. This permits her to examine the subjective feelings evoked in her, and acknowledge to herself what the patient makes her feel or do. In this way she can realize her own potential with respect to her sensitivity in her interaction with patients. This is particularly valuable in formulating a treatment plan and deciding on the management of the patient.

The following principles are important if a nurse is to be able to cope with this type of individual.

First, there is an absolute need for extremely good communication among staff members. Conferences with nurses, doctors, and other health professionals must be held where communication is open and frank. Factors that would render these meetings covert and negative must be brought to the surface and examined by everyone.

Second, early and direct confrontation with the patient about his behavior is important. The patient must be faced in an open, direct way with the standards and limitations expected of him. He needs to be made aware of the social realities of the ward.

The sociopathic personality can spot a phony a mile away. There is no place in dealing with this type of person for humbug or hypocrisy. Having been through the rougher mills of life, he is well aware of what human beings are capable of in playing pseudo roles. It is important that the nurse is a person and not a stereotype where she plays out a role that masks herself from her own unique self. The nurse therefore must be open and honest with the patient, and the patient will respect such encounters. He will often say such things as, "Well I tried, but I couldn't get away with it," or "Well I can see I can't put one over on you."

A sense of humor, a tongue in cheek attitude to statements of melodrama, purple passion, or plain showing off must be handled with warmth and a cool quiet, for the nurse will be constantly confronted by remarks intended to shock and pierce her vulnerabilities. □

books

A Preliminary Report On The Attitudes And Behaviour Of Toronto Students In Relation To Drugs by the Addiction Research Foundation. 176 pages. Toronto, The Addiction Research Foundation, 1969.
Reviewed by B. June Goldberg, Senior Nursing Instructor, University of Alberta Hospital, Edmonton, Alta.

This is a preliminary report of a survey which is part of a larger scale investigation of the character, distribution, and consequences of psychoactive drug use. The report covers a five-month investigation of drug use among students in Metropolitan Toronto high schools. It records the extent of drug use, how students regard this use and the differency in drug usage and attitudes among various age and social groups. Representative sample groups of students were chosen for interviews, and 6,447 students answered questionnaires.

The report covers, in detail, the method of selecting samples and the technique of interviews. This will be of interest to any reader who is a student of sociology.

The report findings will surprise some readers. The study of students in grades seven to 13 found 46.3 percent reporting use of alcohol at least once in the previous six months, 37.6 percent reports use of at least one cigarette per week. More serious perhaps were findings that 9.5 percent had used tranquillizers at least once during the five month survey period, 7.3 percent had used stimulants, 6.7 percent had used marijuana, 5.7 percent had used glue, 3.3 percent had used barbiturates, 2.6 percent had used L.S.D., 2 percent had used other hallucinogens and 1.9 percent used opiates. The vast majority were reports of single usage, indicating that in most cases the drug use is partly and probably experimental.

The report attempts to explore, in some depth, the factors influencing use of drugs. There was a significantly high number of non-users in the A grade achievers and many users reported D and E grades. Similarly, drug users were not achievers in non-academic activities. Influence of parental and peer groups was examined and correlated as to use. Students expressed a need for more and earlier education on drug use and effects. The report analyzes and correlates many interesting factors and the attitudes of students toward these factors.

Two very interesting conclusions are that students depend on and are influenced greatly by their peer groups. However, home and school environment stress achievement and this factor (achievement) is negatively correlated to drug use.

This report, with its extensive statistical tabulation will be interesting reading for all concerned with young people, and will perhaps help each individual to understand the factors leading to drug use and, hopefully, lead to some positive action in combating this problem.

Doctors and Doctrines by Bernard R. Blishen. 202 pages. Toronto, University of Toronto Press, 1969.
Reviewed by Frances Howard, formerly consultant in nursing service, Canadian Nurses' Association.

The medical profession's stand on medicare has met with mixed public reactions depending on the individual's political affiliation, social values, and interpretation of information derived from the news media. This book clarifies the profession's reluctance to endorse government-sponsored insurance plans by identifying the function of ideology in the practice of medicine.

The author has gone to considerable length in describing the education and practice of physicians, which may appear superfluous to some readers. The description, however, is important in that it emphasizes and qualifies the degree of professional independence and autonomy exercised by the profession and its reluctance to accept the inception of an outside control – the federal medicare plan.

The author proceeds to describe the history of provincial medicare schemes, in particular the Saskatchewan plan, the findings of the Royal Commission on Health Services, the action taken by the Federal Government in adopting medicare and the subsequent developments in the various provinces.

Finally, medical ideology is discussed against a background of Canadian social and political history. Stress is placed on the belief of freedom of choice – the physician's freedom to practice according to the standards and ethics of his profession, and the patient's freedom to choose his own physician.

Both sides of the argument have been amply illustrated by statistical reference and by quotes from research studies.

The author makes no attempt to reach a conclusion or to cast blame. Rather, he has presented an unbiased, factual picture of the situation and left the reader to decide for himself.

Fundamentals of Immunology For Students of Medicine and Related Sciences by Russell S. Weiser, Quentin N. Myrvik, and Nancy N. Pearsall. 363 pages. Philadelphia, Lea & Febiger, 1969. Canadian Agent: Macmillan Co. of Canada, Toronto.
Reviewed by Janelyn G. Kotaska, Vancouver, B.C.

This textbook is intended for students of medicine and related sciences, such as veterinary medicine and dentistry. It would be useful as a reference book for nurses at a university level of study, although the material is of a highly technical nature and the terminology is not for a beginning student. The book attempts to clarify and standardize the confusion of varied and often faulty terms that have developed with this relatively new science, but the glossary must be used constantly to understand much of the material in the text.

Immunology is one of the most rapidly advancing areas of biology, and the authors have extracted from the wealth of current research those findings which are significant, employing the "core concept" in medical teaching to stress the fundamentals. Much of the material is beyond the scope of nursing. However, several selected topics would be of interest and value in nursing study: immunologic injury of tissues and organs; mechanisms of inflammation; anaphylaxis; delayed sensitivities; tests involving antigen-antibody reactions; immunology of neoplasms; human blood groups and transfusions; Rh disease; and principles of host-parasite interaction and host immunity to parasites.

The artificial grafting of tissues and organs is dealt with extensively and would help the nurse clarify her understanding of transplants in this area of intense public interest. The discussion includes autografts and allografts, immune response to allografts, graft rejection, and graft versus host reaction.

This text is well-written, with detailed but concise documentation of much data involving all aspects of immunology. It does, however, require that the reader have considerable knowledge of basic sciences, such as biology, physiology, bacteriology, chemistry, bio-chemistry.

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Books and Documents

1. *L'art de vivre en bonne santé* par Wilfrid LeBlond. Montréal, Editions de l'Homme, c1968. 251p.

2. *Bases physiologiques des normes d'hygiène applicables au logement* par M. S. Goromosov Genève, Organisation Mondiale de la Santé, 1968. 105p.

3. *Basic human anatomy* by Helen L. Dawson. New York, Appleton-Century-Crofts, 1966. 332p.

4. *The boke of children;* reprint Edinburgh, E&S Livingstone, 1965. 76p. Exact copy of a specimen of the original ed. published 1553 in the Medical Library, Univ. of Bristol, England.R

5. *Canadian adult basic education* by Michael W. Brooke. Toronto, Canadian Association for Adult Education, 1969. 49p.

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9. *The content and role of collective agreements in Canada* by Félix Quinet. Ottawa, CCH Canadian Ltd. 1969. 1v.

10. *Corporate boards in Canada; how sixty-four boards function* by W. J. McDougall and G. Fogelberg. London, Ont., University of Western Ontario, 1968. 77p.

11. *Creative annual reports; a step-by-step guide* by Frances A. Koestler. New York, National Public Relations Council of Health and Welfare Services, 1969. 71p.

12. *La croix-rouge et la paix* par Henri Coursier. Paris, Spes 1968. 127p.

13. *Current medical terminology* edited by Burgess L. Gordon. 3d ed., Chicago, American Medical Association, 1966. 696p.R

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York, N.Y., National League for Nursing, 1969. 139p.

32. *Nurse's liability for malpractice; a programmed course* by I.h P. Bernzweig. New York, McGraw Hill, 1969. 266p.

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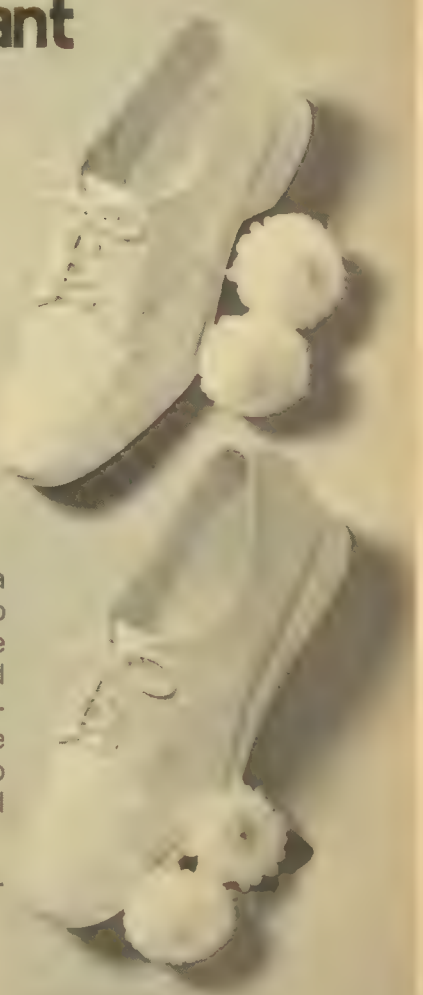
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81. – – –. Women's Bureau. *Women in the labour force, facts, figures.* Ottawa, 1969. 16p.

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88. *Relationship between attitude and person-centered nursing care* by Susan Elizabeth Perry. Boston, 1969. 107p. Thesis (M.Sc.N) – Boston.R □

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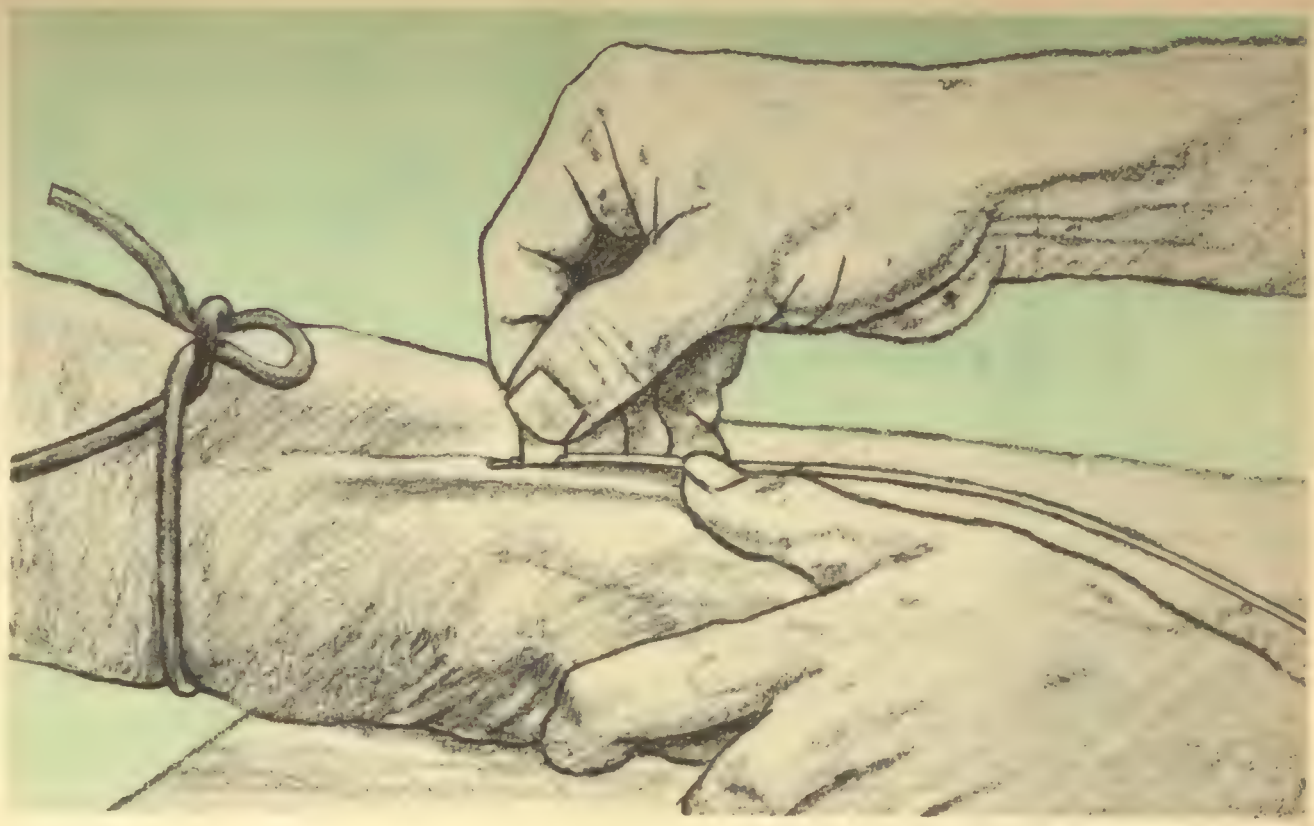
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This month, the month of Remembrance, we decided to look into the past at military nursing. We asked a free-lance writer to talk to several nurses who had served overseas in World War I and write about their experiences. The accounts of these nurses make fascinating reading, filled as they are with pathos, courage, adventure, and humor.

Some of these nursing sisters, who were nicknamed "bluebirds" because of their distinctive blue uniforms, served in England, Belgium, and France. There they saw considerable action, and were in the thick of the battle and the bombings. Many died from shrapnel wounds and many were lost at sea.

Others soon found themselves in remote places, such as Salonika and the Island of Lemnos. In Lemnos, they were faced with more than battle and bombings: heat, dust, flies, dysentry, and malaria plagued the soldiers as well as those caring for them. For the nurses, Lemnos became, indeed, "the Crimea of World War I."

Few service personnel escaped the illness attributed to the unhygienic conditions. The late Nursing Sister M.B. Clint, in her book *Our Bit*, describes how two sisters succumbed:

"Within a few days of each other, the Matron and a sister fell victims to the scourge. As the little cortège of those well enough to attend followed the flag-draped coffins . . . with the Sister's white veil and leather belt laid on them, across the dusty, brown track, some of the patients in my ward were moved to tears. It always seemed a special tragedy to them that anything should happen to the sisters. At that date it was expected that other nurses would die, and . . . the order went forth that extra graves must be ready for eventualities. And, in addition to the fifty [graves] already referred to, a trench to hold six was dug in the Officers' lines. A laconic notice-board bore the legend: "For Sisters only." But whether or not the hilarity with which the premature preparation was received cured our invalids I know not, but no more deaths occurred in the Canadian hospitals. Before we left the area two stone crosses were erected for the Sisters, and the men decorated the mounds with designs in white pebbles. So that there is in that desolate foreign Island, close by the Greek church, a corner that is forever Canada."

V.A.L.

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

In favor of lobbyist

Your article "A Look at ANA's Legislative Program" in the July issue is very informative. I am in full agreement with your opinions concerning a CNA lobbyist in the federal system.

Nurses are the largest group of health workers. The thinking of nursing on health issues as well as some social issues should be heard in committees and by individual members of parliament. In addition, I believe the work of a CNA lobbyist would help those of us who tend to be complacent to become involved in fulfilling our duty as responsible professional people and citizens of a democracy. – Reg.N., Hamilton.

Bring schools up to date

Is there any excitement remaining in learning in schools of nursing? Did all interest stop in public school?

With all the audiovisual aids available to nurse educators, surely we can put some life into the classrooms and libraries to stimulate learning, and, eventually, problem solving in the clinical areas.

I am attending a five-week summer course in Learning Materials Methods. Although it is aimed primarily at teachers in elementary schools, there is much that a nursing instructor could adapt for her students' needs.

For example, suppose the students are studying the basic needs, and are learning to meet hygienic needs of the individual. Several aspects of this would include anatomy and physiology of the skin, normal flora of the skin, perhaps antiseptics that may be applied, and the many nursing measures that can be employed to preserve skin's health. To link all these aspects together, displays – perhaps made by students working in groups – could be set up showing the relationship between different conditions of the skin and its care.

The displays could include charts and models of the structure of the skin; slides showing normal flora; single concept films on pressure areas and methods of preventing decubiti; filmstrips, overhead transparencies, and so on.

My experience in teaching has indicated that classrooms and libraries are seldom used after hours except when an assignment or examination is coming up. Let's make them exciting places to be at other times too. Let's bring nursing education up-to-date! – Mrs. L.E. White, R.N., Scarborough, Ont.

Pen pal wanted

Several months ago, I began reading *The Canadian Nurse* in our school of nursing library. I especially enjoy the letters.

I hope to visit Canada soon. In the meantime I would like to correspond with a young graduate nurse like myself, with whom I could compare notes on nursing and life in Canada and the United States. – Janet S. Jenkins, Route 2, Box 382A, Portland, Oregon 97231.

More reaction to Minister's speech

All Canadian nurses who were unable to participate in the 14th Quadrennial Congress of the International Council of Nurses in Montreal last June should be grateful to *The Canadian Nurse* for printing in its entirety the address given by the Honourable John Munro, Minister of National Health and Welfare. The views expressed by Mr. Munro are worthy of study and comment by every person who is concerned about the health of Canadians and the future role of nursing in our health care delivery system.

In reality, Mr. Munro does not tell us anything new and startling in his call "to join in the total restructuring of the health care delivery system." From one source or another, in one form or another, we have been hearing for some time about the changes necessary in the preparation of nurses and in their patterns of practice if they are to assume a more important role in the future provision of care. On the surface, Mr. Munro's speech would appear to put, once and for all, a national seal of approval on these proposed reforms, even though all his solutions would not find general acceptance within the nursing profession. Nevertheless, the challenge to Canadian nurses is direct and unmistakable. Are we ready for the confrontation?

More important is whether others are ready and willing to help us meet the double challenge of reformation and economy. For example, when Mr. Munro suggests that "the nursing profession as a whole shouldn't be dependent on hospital work in the same way as an infant depends upon the umbilical cord," do he and others in his orbit support the transfer of the bulk of nursing education from its traditional link with hospitals into the framework of general education? What more immediate way to cut hospital costs and, at the same time, provide a new focus – i.e., moving out into a larger community – for the preparation of nurses? Mr. Munro is quite correct in reminding us that all the proposed moves "cannot be accomplished without the active participation of nurses," but it is equally valid that others should not be allowed to block the way to success.

Truly, as Mr. Munro puts it, "reform and reorganization must come," and having his address for future reference should assist all Canadian nurses to judge the rate and degree of our progress. – (Mr.) Albert W. Wedgery, Reg.N., Associate Director, College of Nurses of Ontario, Toronto.

Letters Welcome

Letters to the editor are welcome. Because of space limitation, writers are asked to restrict their letters to a maximum of 350 words.

The Honourable John Munro, in his address reprinted in the August issue of *The Canadian Nurse*, points clearly to the need for change in Canadian health service. The challenge to reform health service delivery without bankrupting the common treasury can be met by cooperative planning among all groups of health workers. For an expanded role for nurses to increase the effectiveness of health services, the role must fit into the total picture of services and its usefulness must be accepted by other health workers.

I believe we are ready to accept an expanded role. This is not a new concept in some of its aspects. For example, when nurses began to take blood pressure readings and conduct well-baby conferences, our role expanded. Perhaps the difference in the current proposal is that the nurse would be accountable for the patient during an acute phase of illness with infrequent supervision or with merely a consultant relationship on the part of the physician (Mr. Munro's example – "follow-up visits on treatment prescription.")

Mr. Munro said, "the nursing profession as a whole shouldn't be dependent on hospital work in the same way as an infant depends upon the umbilical cord" and also, "more nurses can be trained in the specialized field of home care and home nursing." These two points, I believe, are related. I assume Mr. Munro is not making a distinction between public

(Continued on page 6)

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letters

(Continued from page 4)

health nursing and home nursing. Home nursing could mean giving private duty care to one patient in his home. However, this activity does not require the nurse to "be trained in the specialized field." Thus relating the two points above, one obvious reason for dependence on hospital work is that the majority of nurses are not prepared for the public health field.

Mr. Munro suggests that more nurses should be trained in the specialized field of home care and home nursing. Might it not be advisable to prepare all nurses for public health nursing in their basic education? What other profession requires its members to specialize in order to change their locale of practice from an institution to the home and community? To give professional service, the nurse caring for the patient in the hospital must be capable of evaluating the many forces that affect the ability of each patient and his family to cope with health problems. Does the setting make much difference?

Perhaps the question of whether the "expanded role" is different in kind from previous additions to nursing practice is academic. Perhaps a feldsher system, mentioned by Mr. Munro, is the answer. But, in any case, I believe our fundamental responsibility as individual nurses and as a professional group is to be forthright in our commitment to provide and direct the provision of nursing care to all persons who require it. The demonstration baby bath; feeding of a helpless patient; helping a family organize its members to care for an invalid member; bathing and changing the bed linen of an unconscious patient; helping a patient talk out his fears preoperatively, are examples of nursing care.

These functions are not glamorous; but they and other unglamorous activities constitute nursing care. As we expand our role, we as a profession must retain responsibility for the provision of nursing care. – Myrtle Kutschke, Reg.N., Hamilton.

The Minister of Health's speech at the opening plenary session of the International Congress of Nurses revealed a compassionate understanding and concern for our nation's needs. Truths were said throughout, albeit with political overtones; yet it was evident his main concern was not only in the reduction of the animated dollar sign.

Mr. Munro seemed cognizant of the social and health problems of our country, which are precipitated by the disparities in availability of medical and nursing service. Although there were many platitudes in his talk, he did not hesitate to remind the listener that some selfish motives may underly the present system of care.

His criticisms, kindly said, and his solutions to the problems have provided the nursing profession in Canada with the biggest challenge any government has asked of it. One cannot help but feel honored that we are so highly regarded. It also stimulates one to do a little soul searching. Are members of the profession ready to accept his challenge, or is the "pew" too comfortable? Is it realistic to believe that Canadian nurses are concerned about society's needs and the "have not" places? One has only to be in charge of a nursing service department in a hospital and contend with mobility of staff, reluctance to do shift work, absenteeism, and summer resignations to become a little cynical.

Mr. Munro's speech was so nationally oriented that it may have held little for the international visitor to the Congress. It would seem more appropriate for the Canadian Nurses' Association biennial. Perhaps he will favor us again, and in a setting where open discussion can take place. His ideas are excellent, and his support is what is needed to do something concrete about meeting his challenge. – E. MacLeod, M.S., Director of Nursing, Prince Edward Island Hospital, Charlottetown, P.E.I.

I agree wholeheartedly with the Honorable John Munro's statement, "Hospital dependence and its high expense . . . can be reduced by moving out into the community." Not only can the expense be reduced, but we have demonstrated many times during the past 10 years that organized home care programs can give "the right care at the right time in the right place." Many patients are ready for discharge from hospital as far as their medical needs are concerned and should be discharged to meet their emotional needs.

Home care programs have demonstrated that the community nurse, working with the physiotherapist, social worker, speech therapist and homemaker – all under the direction of the family physician – can accomplish miracles in keeping patients out of hospital, preventing readmissions, holding families together, and helping older couples stay at home together for the remainder of their married lives. To try and estimate the savings to the taxpayer by these "miracles" would be impossible.

Necessary funds should be made available for new home care programs and for expansion of existing ones. Thorough investigation should be made of some barely tapped sources of patients, such as pediatric patients, short-term surgical patients, patients having minor surgery on an outpatient basis, and some postnatal

and newborn patients. Patients now in nursing homes, convalescent homes, and geriatric centers could eventually be discharged to home care programs, if physiotherapy were available in the nursing home. For some, the nursing home could then become a stopping off place en route home, rather than the place where hope dies.

This is clearly illustrated by a pilot project conducted by the Saskatchewan Division of the Canadian Arthritis and Rheumatism Society. The project, "The Provision of Physiotherapy Services to Sherbrooke Nursing Home, Saskatoon, Sask.," showed that many patients in this nursing home needed physiotherapy but were unable to pay for either the service or the necessary transportation; nor did they have the stamina to make the trip to an outpatient clinic.

If this service could become a part of these institutions, it would open up this great source of patients for the home care team, and help to reduce health care costs to the taxpayer. As well, it would allow many to live their lives within the dignity of their own homes.

I am delighted that the minister of health advocates "moving out into the community." I hope that his vision will become evident at both federal and provincial policy levels. – Ruth Crichton, Co-ordinator, Saskatoon Home Care Program.

One of the highlights of the International Congress of Nurses was the address by the Honourable John Munro, Minister of National Health and Welfare. His words warmed the hearts of those nurses who recognize the need for greater emphasis to be placed on the prevention of disease and the provision of facilities for rehabilitation and care of the disabled.

Many shared his beliefs concerning the need for nurses to play a larger role in the health services. Rather than introduce new members to the team, we believe there is need to examine the roles of those presently contributing, to ascertain if, with adjustments in education and legislation, the existing members could not be qualified and licensed to meet the needs of the people in all parts of Canada. To the nurses' traditional role could be added the responsibility for planning and coordinating health care, teaching patients and their families in hospitals and in homes, methods for the prevention of disease and the avoidance of complications arising out of an illness. Nurses could be qualified to accept responsibility for an expanded role in maternal and child care, and in certain aspects of the care of acute and long-term illness. To take such responsibilities, the pattern and content of nursing education would need to be reexamined.

For years, nursing leaders have regretted the expenditure of large sums of money on single discipline schools of nursing and nurses' residences attached to hospitals. The barriers to change have, at times, appeared to be insurmountable. Now, reform is taking place in some provinces, but is being delayed in others.

Student nurses should be educated in multi-disciplinary schools with other members of the health team, some of whom should be prepared in universities and some in diploma schools. They should live, as other students do, in their own homes or in residences shared with students from other disciplines. The cost of their education should be met on the same basis as other post-secondary education. Many of the existing nurses' residences should be shared with students in related disciplines. Some could be converted into long-term illness and rehabilitation centers, for which there is a pressing need in most communities. The content of the curricula in schools of nursing should reflect changes arising from advances in knowledge and new patterns for the delivery of health care. Students in the health professions should have the opportunity for appropriate

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Photo credits for November 1969

Photo Features, Ottawa, p.11

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letters

shared educational experiences, including, for example, some lecture courses, case studies, and clinical practice.

The challenge placed before us by the Minister of National Health and Welfare is clear. We need to reform the system for the delivery of health care, and to extend essential services to all Canadians with due consideration for economy and efficient use of personnel. To achieve the goal set by the Minister, we will continue to need strong leadership in our own profession and the commitment of each of the health professions to this goal. Coordinated effort will be needed. We trust the professions will accept this challenge and give leadership to constructive measures to improve and expand the health services, so that the education for the health professions is attuned to the times. – Helen M. Carpenter, Director, University of Toronto School of Nursing.

It seems fitting that the journal published the address by the Minister of Health, the Honourable John Munro, in its entirety (August 1969).

Health costs and distribution of health care are Mr. Munro's concern for the Canadian people, but also more significant is his concern for the different roles played by the professions in the delivery of health care. There is no doubt that nursing could accept a broader role in health care. However, lines of responsibility and authority need to be clearly defined, and it is only by dialogue between the medical and paramedical groups that this can be accomplished.

Public health nursing and the philosophy of prevention, education, and home nursing as expressed by and through the minister's address is reassuring to nurses in the public health field. Public health nursing can now hope for a larger share of the public health budget. This would be "a shot in the arm" to raise the ratio of public health nurses in Canada beyond the present five percent of the total registered nurses working in this country.

Let us now hope for some action! – Apolline Robichaud, Director, Public Health Nursing, Fredericton, N.B.

Nursing Outlook wanted

If anyone has the following editions of *Nursing Outlook* and would be willing to donate them for the new diploma nursing program at Humber College of Applied Arts and Technology, we would be most appreciative: 1964 – July and December; 1965 – May and October; 1966 – July; 1967 – March, May, and August; 1968 – January.

The address of the college is Humber College Blvd., Rexdale, Ontario. – Mrs. Marilyn Barras, Director, Department of Nursing, Humber College of Applied Arts and Technology.

Identification of staff

I was interested in the letters "Uniforms create invisible barriers" and "Caps and uniforms" (April and May, 1969).

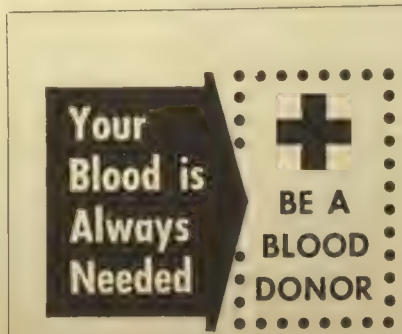
I do not agree that nurses should discard their uniforms. The uniform of a nurse is one of the outstanding uniforms of the nation. It has been through two wars and the peace between, and is recognized throughout the world. I believe that the nurses themselves should guard the uniform which only they are entitled to wear. However, I am happy to know that nurses are concerned about it.

If the hospitals put nurses in civilian clothes, the patients are going to wonder what happened to the nursing profession. A nurse's uniform assures the patient of the necessary standards of hospital cleanliness. I agree with Dr. Black (Letters, December 1968) that a nurse must wear a uniform to be a nurse, and I feel proper identification of staff is very important.

In Alberta, the patient often cannot recognize the graduate nurse now that the nursing aides are allowed to wear the traditional white uniform of the graduate nurse. Knowledge and skill identify a nurse, but so does a uniform, because she wears it on duty and is recognized as a skilled, professionally-equipped person. Her cap and black band indicate the experience she has earned. If we have any pride in our profession we should fight to keep our nursing uniform, and be aware that white uniforms and caps belong in hospitals – not a washable dress of any color or style, which is a disgrace to the nursing profession. – Mrs. Minard, R.N., Calgary, Alberta.

American Journal of Nursing

Would anyone having copies of the following issues of the *American Journal of Nursing* please write to: Mrs. K. Whatley, Librarian, Lakehead Regional School of Nursing, P.O. Box 1165, Port Arthur, Ontario: March, 1961; March, April, 1962; February, July, October, 1967. □



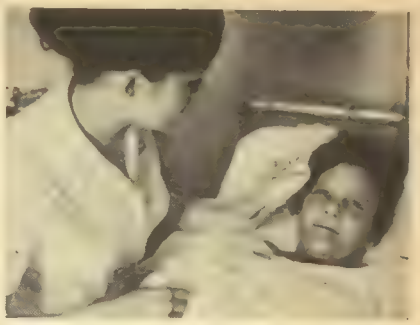
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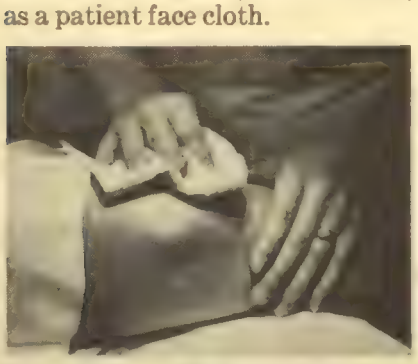
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news

CNA Special Committee Will Report To Board

Ottawa. – The report of the special ad hoc committee on functions, relationships and fee structures will be presented to the board of directors of the Canadian Nurses' Association when it meets in Ottawa November 4, 6 and 7, 1969. Committee chairman Jeanie S. Tronningsdal will attend the meeting to give the report and to answer questions from the board.

The committee held its last meeting September 25 to 27 in Ottawa. Mrs. Tronningsdal said then that committee members felt they had not had as much time as they would have wished to prepare the report. However, she said, the committee decided it must have its report available for distribution to the board in November to give provincial nurses' associations the required six months to study the report before CNA's biennial meeting in June 1970.

The committee was set up at the 1968 biennial meeting in Saskatoon to investigate the questions of fees and the divisions of labor and responsibilities between the provincial and national associations. Members of the committee include: Mrs. Tronningsdal, Calgary; Madge McKillop, Saskatoon; Marie Sewell, Toronto; Madeleine Jalbert, Quebec; Marilyn Brewer, Fredericton; Dorothy Wiswall, Halifax; Sister Mary Irene, Charlottetown; Janet Story, St. John's.

Health Care Fragmented Labor Leader Tells Assembly

Ottawa. – The present system of the delivery of health care services is highly fragmented, a professional trade unionist told 200 delegates attending the first National Health Manpower conference in Ottawa October 4-7.

Speaking as a panel member at the opening session of the conference, Andy Andras, director of legislation, Canadian Labour Congress, said that a comprehensive system of health care is needed now, but is not being provided and is not likely to be provided with the present system of organization. Mr. Andras questioned the quality of health care now being provided, and pointed out that not all persons in Canada are getting the care they require.

"Territorial justice is needed," he said. "By this I mean that all people – whether they live in British Columbia or Newfoundland, in the north or south, should have access to medical services."

Mr. Andras said that in any development of manpower, professional self-interest that would create obstacles to manpower supply must be avoided. He warned the assembly against a too conservative approach to the planning of health services delivery for the future. "Most people are prepared to pay for health services through collective action," he said, "but the costs must be borne equitably.

Other panelists at the opening session were: Bernard Blishen, dean of graduate studies, Trent University, Peterborough, Ont.; Charles E. Hendry, consultant, research and planning, Department of Social and Family Services for Ontario; Dr. John Maloney, honorary treasurer, Canadian Medical Association; and Mrs. Beryl Plumptre, president, Vanier Institute of the Family. Dr. Jacques Gelinas, deputy minister of health for the Province of Quebec, chaired the session.

The four-day National Health Conference was sponsored jointly by the Department of National Health and Welfare and the Association of Universities and Colleges of Canada. Its objectives were to secure agreement on guidelines for planning the delivery of total health services during the next decade, determining the numbers and quality of the health manpower required for these services, and planning the education of the required health manpower. Persons attending the conference and participating in its sessions represented consumer groups, government planners, professional associations, universities and colleges.

Panelists Discuss Education For Health Workers



Lois Graham-Cumming, director of research and advisory services for the Canadian Nurses' Association, was one of four panelists who discussed "Health Manpower Education – The Challenge to Educational Institutions" at the National Health Manpower Conference held in Ottawa October 7-10. Other panel members were: Professor L.-P. Bonneau, vice-rector, Laval University, Que., chairman of the session; Dr. H.M. Scott, assistant professor of medicine, McGill University; Dr. J.R. Evans, dean of medicine, McMaster University, Hamilton; and Dr. J. Brunet, professor, Laval University.

Plans Underway For CNA Convention

Ottawa. – Between 850 and 1,000 nurses from across Canada are expected

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to attend the 35th biennial convention of the Canadian Nurses' Association in Fredericton, New Brunswick, June 15 to 19, 1970. And the host association, the New Brunswick Association of Registered Nurses, promises visitors warm hospitality, including plenty of accommodations.

Hotel space in Fredericton is limited, but ample accommodations have been arranged at the residences of the University of New Brunswick, according to CNA business manager Ernest Van Raalte, who attended planning sessions with NBARN in Fredericton in September. Those staying in the residences will have the advantage of a pleasant parkland setting minutes from the center of town, he said. Specially scheduled public transportation will be available morning, noon, and night between residences and the Playhouse theatre, with cafeteria facilities close by.

All main sessions of the convention will be held at the Playhouse. Space for clinical and special interest sessions will be provided in the university's auditorium.

The chairman of NBARN's biennial planning committee is Catherine Bannister; vice-chairman is Diane Flower.

CNS Works With DBS To Publish Statistics

Ottawa. – A request for statistics on nurses' salaries first made by the Canadian Nurses' Association in 1967 to the Dominion Bureau of Statistics has resulted in a recently published DBS survey for 1968, *Annual Salaries of Hospital Nursing Personnel.*

This 47-page survey is an extension of a study DBS conducted in February 1967. As stated in CNA's *Countdown* 1968, information on salaries of full-time graduate nurses employed in the public general and allied special hospitals in Canada was collected and tabulated by DBS in 1967, at CNA's request and with the support of the Canadian Hospital Association.

At CNA's suggestion, the 1968 DBS survey was extended to include mental hospitals and TB sanatoria. In addition, the salaries of qualified nursing assistants in these institutions, as well as in the public general hospitals, were included.

CNA worked jointly with DBS to design the questionnaire used in the 1968 survey, and to provide the definitions of terminology. Beginning in October 1970, DBS, at the request of CNA and the Canadian Public Health Association, will start a salary study of public health nurses in official agencies. It is hoped that this study will be expanded in 1971 to include public health nurses in non-official agencies in Canada.

Nurse Included In Canadian Delegation To WHO Assembly

Ottawa – The Canadian delegation to the Annual Assembly of the World Health Organization this year included a nurse member. Verna Huffman, principal nursing officer, Department of National Health and Welfare, was among a number of public health leaders in the country designated by the federal government to represent Canada.

"The significance of the inclusion of nursing officers in official delegations to the assembly is recognition that nursing has a place with other health personnel in planning for the health of the world," Miss Huffman said in an interview with *The Canadian Nurse.*

The 22nd World Health Assembly was held in Boston in July at the invitation of the United States' government on the occasion of the 100th anniversary of the Massachusetts Department of Public Health. It was the fifth time an assembly had been held outside WHO Headquarters in Geneva, Switzerland.

The 131 delegations from WHO member states included about 1,000 representatives. Nurses from two countries were official delegates: Miss E.M. Githae, the chief nursing officer for Kenya, and Miss Huffman.

Also attending the assembly, as observers, were representatives of non-governmental organizations: Dr. Irene S. Palmer, School of Nursing, Boston University, represented the International Council of Nurses; and Miss Anny Pfirter represented the International Committee of the Red Cross.

Plenary sessions, committee sessions, and technical discussions were conducted during the assembly. The technical discussions provided an opportunity for delegates and observers to speak as experts in their respective fields rather than as representatives of member countries.

The theme of the technical discussions was The Application of Evolving Technology to Meet the Health Needs of People and dealt with health manpower and the changing roles; education and training to meet the changing roles; and the administration and organization of health service. Other topics discussed during the assembly were: 1. the use and effects of drugs; 2. population planning; and 3. ways to reduce dental caries.

A debate was held concerning malaria eradication. The assembly reaffirmed its objective of global control, modifying its approach to a regional rather than a country basis. It was also recommended that efforts be made to find a substitute for DDT that has less residual effects. Several delegates reported action to ban its use in their countries.

(Continued on page 15)

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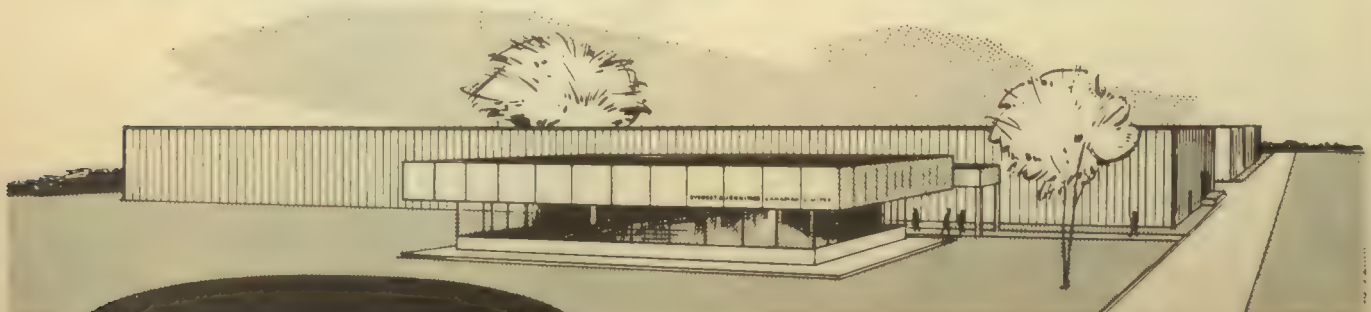


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news

(Continued from page 13)

AARN Holds District Rallies To Study Bill 119

Edmonton, Alta. – The Alberta Association of Registered Nurses is holding rallies throughout the province so its members can study in detail Bill 119, a Bill tabled by the Alberta government during its last session to set up a council of nursing in the province.

Bill 119, designed to bring the control of licensing, education, and discipline for all types of nurses, nursing aides, and orderlies under a provincial council, has met stiff opposition from almost all registered nurses in the province. The main complaint of the nurses is that the autonomy of the profession would be reduced considerably if the Bill were passed by the legislature, and that major decisions would be made primarily by persons outside the profession who are unqualified to make such decisions.

Under the proposed Bill, only four of the 16-member council would be registered nurses; three of these RNs would be appointed by AARN, and one, by The University of Alberta's faculty of nursing. Non-nurse members of the council would include: four political appointees; one person appointed by the Psychiatric Nurses' Association of Alberta; one member representing mental deficiency nurses; an appointee of the Alberta Association of Nursing Orderlies; an appointee of the Alberta Certified Nursing Aide Association; a member appointed by the College of Physicians and Surgeons of the province; two members appointed by the Alberta Hospital Association; and one member appointed by the Catholic Hospital Conference of Alberta.

In an open letter to the former minister of health, J.D. Ross, the president of the Lethbridge Chapter of AARN, L. Laqua, objected strenuously to the structure of the proposed council. In particular, she expressed concern that four of the 16 council members would be political appointees. "This is gross political interference in a professional body," she wrote, "unknown in a democratic society." Miss Laqua pointed out that three members of the council would be employers of nurses. "A fine setup where employers licence their employees," she commented. "An irritable thorn in their side, from some crusading nurse, could easily be removed at the stroke of a pen."

Bill 119 also calls for a nursing education committee to be formed from the 16-member council. Nurse educators who were not on the committee would be excluded from acting on it.

Under the Registered Nurses' Act of 1966, the AARN is authorized to decide who is eligible to become a registered nurse in the province, and to discipline nurses. Nursing education in the province is the responsibility of the Nursing Education Committee of the Universities Coordinating Council – a responsibility given to the University of Alberta by AARN.

In a telephone interview with *The Canadian Nurse*, M. Geneva Purcell, president of AARN, said that rallies have been held across the province to interpret the Bill and to get members' reactions. She explained that AARN did not object to the setting up of a council *per se*, but believed that the council proposed by the government would have far too much control over the nursing profession.

AARN has set up a task committee to prepare a composite report of the responses from its members concerning Bill 119. A brief from the association will be sent to the Alberta governement.

Arbitration Award Angers Ottawa Civic Nurses

Ottawa. – The Ottawa Civic Hospital Nurses' Association signed a one-year contract in October with the hospital, following months of negotiations that had ended in deadlock before an arbitration board was appointed.



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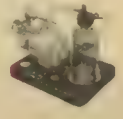
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news

Mary Lou Annable, head of the 510-member association – one of the largest in the province – told *The Canadian Nurse* that this arbitration award contains more unmet demands than any other nurses' settlement in the province.

The arbitration board's report, which was not signed by the association's nominee on the board, gives the hospital's graduate nurses and nursing instructors a 6.7 percent salary increase. Head nurses and supervisors are excluded from the association. Under the new salary scale at the Ottawa Civic, a general staff nurse registered in Ontario earns a minimum of $475 per month, with a maximum of $575. In the last contract the starting salary for a registered nurse was $445 per month.

The nurses' association originally asked for $525, but agreed to settle for $500. However, the hospital refused to offer more than $470 per month, the amount recommended by the Ontario Hospital Services Commission. Efforts by a conciliation officer failed, and an arbitration board was then appointed.

"The patient will suffer in the end," Miss Annable said. This past summer at the hospital was the worst ever because of a serious shortage of nurses, she explained. Nurses at other Ottawa hospitals were earning $470 per month, compared with $445 at the Civic.

Looking ahead to next year, Miss Annable said that the OHSC is calling for an eight percent salary increase, or $510. "Guelph nurses are already receiving $525 this year," she said.

Other nurses' demands *not* granted by the arbitration decision included: an eight-hour work day – nurses will continue to work an eight and one-half-hour day, which includes a half-hour lunch break; uniform allowance; one and one-half days sick leave per month – one and one quarter days remains unchanged; and time and one-half for working on a statutory holiday when regularly scheduled to do so.

One issue that the nurses particularly could not understand, Miss Annable said, concerned annual vacations. The hospital asked that the vacation period remain the same, she said, but the arbitration award took one of the four weeks away from nurse technicians – nurses who work on a blood team, administering intravenous infusions and giving intravenous medications and drugs – and refused to grant staff nurses the four weeks vacation requested.

In his dissenting brief to the arbitration board, the nurses' representative, D.F.O. Hersey, said, "In the very important monetary area of the dispute, the majority ignored a 12.5 percent wage increase . . .granted to other employees at the Ottawa Civic Hospital, and have adopted the Ontario Hospital Services Commission rate, plus $5 . . . .

"It is only for nurses that the OHSC publishes specific rates," he said. "The other hospital occupations are apparently controlled by general permissable percentage increases or operating budgets."

The arbitration board did not give reasons for its refusal to meet the individual demands of the nurses' association. According to arbitration board chairman J.H. Brown, Q.C., and the hospital representative, A.J. Clark, "Our award represents the balancing of many factors all in the context of the entire collective agreement."

The Registered Nurses' Association of Ontario helped the nurses' association throughout its contract negotiations. The RNAO supplied data on other Ontario hospitals that the association presented to the arbitration board.

The contract is retroactive to January 1, 1969, and extends to December 31, 1969.

NBARN Awards Scholarships

Fredericton, N.B. – A total of

(Continued on page 19)



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*Kehlmann, W. H.: Mod. Hosp. 84:104, 1955

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(Continued from page 16)

$2,000 in scholarships has been awarded by the New Brunswick Association of Registered Nurses to four nursing students undertaking university study leading to a baccalaureate degree in nursing.

Recipients of the annual NBARN Scholarship are Marielle Bossé of St. Jacques, and Mary Jane Scott, Bathurst. The annual Muriel Archibald Scholarship was awarded to Arleen Brawley, RN of Saint John and Mary McSheffrey, RN, Oromocto. The awards are for $500 each.

Miss Bossé is a student in the basic nursing program at the University of Moncton, and Miss Scott is enrolled in the basic program at the University of New Brunswick School of Nursing, Fredericton. Miss Brawley and Miss McSheffrey, both registered nurses, are undertaking university study leading to a degree in nursing. Miss Brawley is enrolled at the University of Ottawa, and Miss McSheffrey is attending the University of New Brunswick.

RNABC Urges Protection For Nurses

Vancouver, B.C. – The Registered Nurses' Association of British Columbia will ask the British Columbia Hospitals' Association to review hospital policies and procedures relating to the safety of night workers in hospitals. The RNABC has also offered to make $1,000 available for research to study the problem of safety.

This action was prompted by the recent fatal stabbing of a nurse from St. Paul's hospital, as she returned home from work after midnight.

Immediately after this tragedy, St. Paul's established a continuous inservice program on self-protection for all personnel, and has increased parking facilities for the afternoon staff.

"Many public spirited citizens have volunteered transportation," said Mrs. A. Murray, director of nursing service at St. Paul's hospital. "All have been carefully screened and a transportation system has been established under the direction of an administrative assistant."

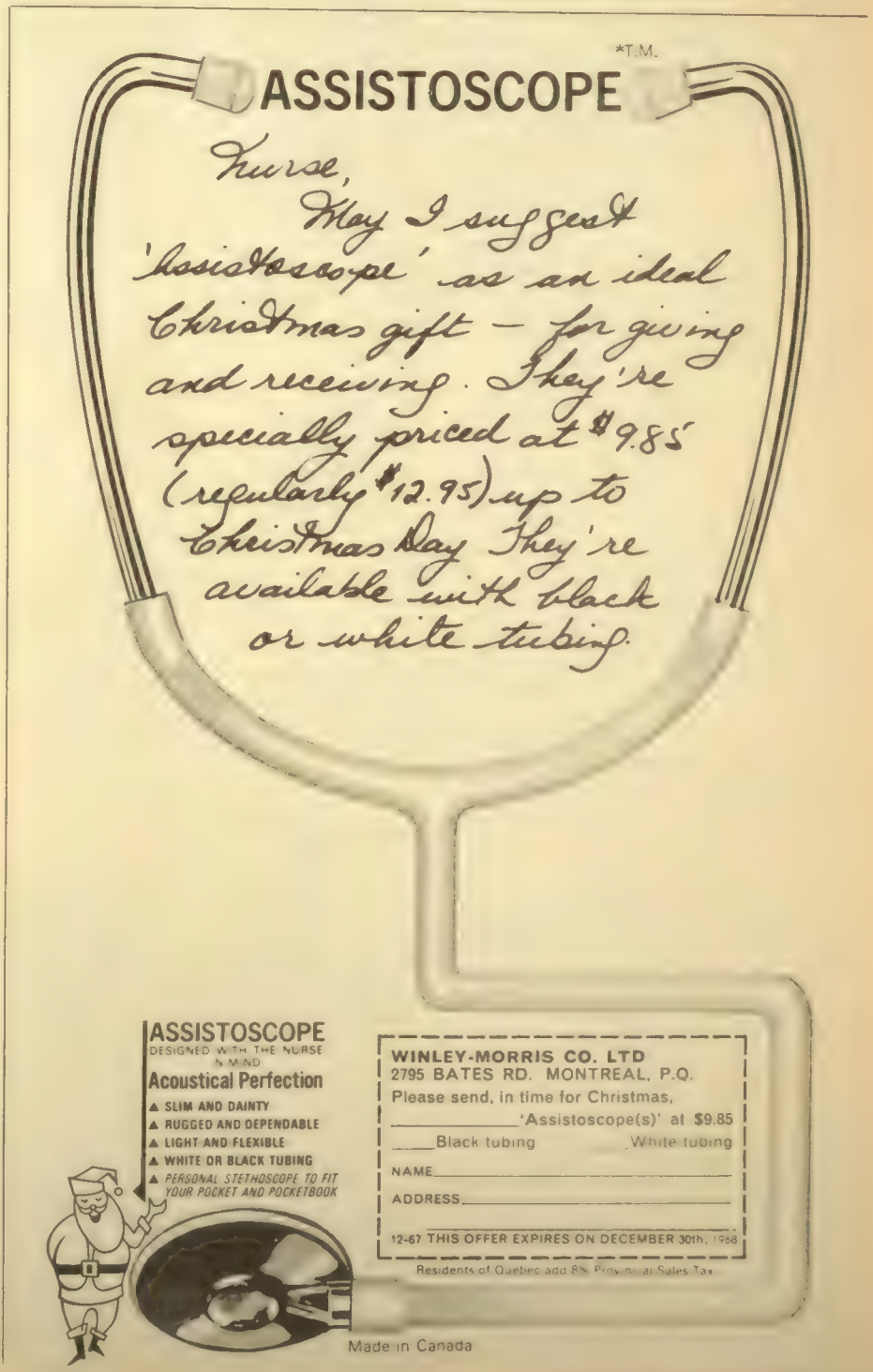
The RNABC has commended St. Paul's Hospital for its prompt action and has offered whatever services it can to the hospital in finding solutions to the problem.

The association will urge the British Columbia Hospital Insurance Service to provide funds to educate hospital workers in self-protection, especially when commuting to and from work. A letter has been sent to the mayor and council of the City of Vancouver expressing RNABC's concern about the inadequate police protection and lighting, particularly in the west end of the city.

A covering letter with copies of these expressions of concern will be sent to Premier W.A.C. Bennett, Health Minister Ralph Loffmark, and Attorney-General Leslie Peterson, indicating the association's view that the suggestions made are palliative measures only.

The *Labour Standards in Canada* cites two provinces, Ontario and Manitoba, with laws that require an employer to provide free transportation for all female employees whose shift begins or ends between midnight and 6:00 a.m. Laws in Alberta, Saskatchewan, and Quebec exclude nurses from this provision. In the other provinces, no law governs night work for women.

Following the release of information from the RNABC, *The Canadian Nurse* conducted a telephone survey of several hospitals in major centers across Canada to determine what provision they make for the safety of nurses changing shift at night. The results of that survey will be reported in an article in a future issue of *The Canadian Nurse.*



news

Two Nurses' Associations Certified To Bargain In Nova Scotia

Halifax, N.S. – Two nurses' associations have been certified to bargain for 55 nurses in Nova Scotia. The staff nurses' association of the Highland View Hospital in Amherst, Nova Scotia became the Labour Board of Nova Scotia. On September 16, the staff nurses' association of the Sutherland-Harris Memorial Hospital became the certified bargaining agent for 17 nurses. All nurses except the evening and night supervisor were included.

Margaret Bentley, employment relations officer for the Registered Nurses' Association of Nova Scotia, said the Highland View certification was an important step for the RNANS. "Our own Act did not permit us to be certified as an association because we have all types of members, so we had to decide whether to amend our Act or try for certification under The Trade Union Act," she explained.

Mrs. Bentley said that after much thought and discussion they chose the Trade Union Act. "We state our aims and objectives in our staff association constitutions and in this way we feel we are not lowering our professional standing in any way," she said.

Hospitals in Nova Scotia submit budgets to the Hospital Insurance Commission, which recommends a salary guide. Mrs. Bentley explained that most hospitals pay the basic recommendation of $425., although they do not always pay increases.

On September 16, the staff nurses' association of Highland View Hospital began negotiating its first contract.

NBARN Holds Meeting To Vote On Fee Increase

Fredericton, N.B. – A special general meeting of the New Brunswick Association of Registered Nurses has been called for November 20, 1969 in Fredericton. The purpose of the meeting is to vote on a fee increase from $30 annually to $40 annually, effective January 1, 1970.

The special meeting was called in response to a resolution presented at the association's annual meeting in May. The resolution stated that all NBARN services presently offered to the members and the community are essential and that it would be beneficial to both groups if services were enlarged. Since the association's income is not sufficient to support all essential services, it was resolved to call a special meeting to consider a fee increase.

NBARN's proposed budget for 1969 is a deficit budget.

RNAO Survey Shows Disparity In Salaries

Toronto. – A marked diversity in the salaries and working conditions of occupational health nurses was shown in a recent Toronto area survey conducted by the Registered Nurses' Association of Ontario.

Of 35 occupational health nurses receiving questionnaires, 23 replied. Salaries ranged from $5,100 to $8,100 a year, but the four nurses whose years of service with their present employer varied from 15 to 23 included one who had a salary of only $5,400. This was $900 a year less than the highest among those with less than three years service and $204 less than average among those with less than three years service.

Also, the lowest paid nurse with three to six years of service received $1,144 more than the lowest paid nurse with six to nine years service, and the average salary of those with three to six years service was $1,183 more than the average of those with from six to nine years service.

Shortest service reported was six months and the longest 23 years, with the average being 7.7 years. The average salary for all was $6,404.61. The number of paid holidays varied from 8 to 11.

Employer contribution to medical, surgical, and hospital insurance plans varied from 33 percent to 100 percent. All nurses replied that they had some provision for income protection during illness.

Most employers provided uniforms and/or laundering of uniforms. Fourteen nurses received two weeks holidays after a year and nine received three weeks. Hours of work varied from 35 to 40.

UNM Elects New Officers

Montreal, P.Q. – The United Nurses of Montreal elected Gloria A. Blaker as president of the association at the annual meeting in September. Mrs. Blaker, who is fully bilingual, won over four other candidates for the office. A recent decision of the association established the presidency as a full-time, paid position.

In presenting her views to members of UNM, Mrs. Blaker cited three areas of concern: communications, money, and professional and working programs. Calling for a greater public understanding of the changing role of the nurse, she stated, "The role of nurses . . . must be defined to include the right and the responsibility of determining our own future in a changing society."

The UNM, which represents over 3,000 nurses in Montreal hospitals, agencies, and companies, has been negotiating a new contract with the Association of Hospitals of the Province of Quebec since April 1968.

Other officers elected by the United Nurses of Montreal are: Sandra Taylor, second vice-president; Anne Raudsepp, treasurer; and Barbara Richards, Loraine Brazeau and Marjorie Iwamoto as directors of the executive board.

Elected from the associate members were: C. Robertson, first vice-chairman; K. Grant, secretary; and A. Mountjoy, F. Vincent, and E.J. Pearson, as members of the board of directors.

Contracts Signed By Saskatchewan Nurses

Regina, Sask. – Since the conclusion of collective bargaining agreements between the Saskatchewan Registered Nurses' Association and the Saskatchewan Hospital Association committees on May 5, 1969, 14 hospitals have signed contracts of employment with their staff nurses' associations. Most of the remaining hospitals have applied the terms of the SRNA-SHA agreement as personnel policies.

The collective bargaining carried out under voluntary recognition sets out salaries and working conditions for head nurses, instructors, assistant head nurses, and general staff nurses.

The Saskatchewan Hospital Services Plan has agreed to honor the terms of the SRNA-SHA agreement, except for the four weeks' vacation demand. SHSP recognizes only three weeks' vacation.

The two-year term of the contracts provides salary increases in stages. As of September 1, 1970, the starting salary for the beginning nurse will be $500.; for the nurse with one year or more of experience, $550.

Student Enrollment Increases In Nova Scotia

Halifax, N.S. – Information received from the Registered Nurses' Association of Nova Scotia shows that enrollment in schools of nursing in the province has increased considerably this year.

In September, 500 students entered the six diploma schools of nursing and the three degree-granting institutions. This is an increase of 210 over last year.

The diploma schools of nursing in the province are at: Victoria General Hospital and Halifax Infirmary, Halifax; Sydney City Hospital, Sydney; Yarmouth Regional Hospital, Yarmouth; Aberdeen Hospital, New Glasgow; and Saint Martha's Hospital, Antigonish. Universities offering degree programs in nursing are: Dalhousie University, Halifax; Mount Saint Vincent University, Halifax; and Saint Francis Xavier University in Antigonish.

Ryerson Institute Offers Short Courses For RNs

Toronto, Ont. – The nursing department of Ryerson Polytechnical Institute is now offering short courses for the registered nurse who wishes to improve her knowledge and skills in psychiatric nursing, pediatric nursing, or adult intensive care nursing.

Each of the courses offers a balance of supervised clinical practice, nursing classes, and classes in the related sciences and humanities, taught by experts in their area. At present the courses are all approximately 15 weeks (one semester) in length, although the psychiatric nursing program will be expanding to two semesters, probably in September 1970.

Both the psychiatric and pediatric nursing courses are now in progress. Applications are now being received for the adult intensive care nursing course, which will commence in January 1970.

Applications for the pediatric and psychiatric nursing courses in September 1970 will be accepted for processing after January 1st, 1970.

Application forms and information for these advanced courses are available from the registrar, Ryerson Polytechnical Institute, 50 Gould Street, Toronto 2b, Ontario.

RNABC Announces Awards

Vancouver, B.C. – The Registered Nurses' Association of British Columbia has made $6,000 available this year in bursary-loans for nursing education.

A bursary-loan of $2,000 has been awarded to Mrs. Ada Butler of Vancouver for master's study at the University of British Columbia. She is a graduate of The Vancouver General Hospital's School of Nursing and obtained her bachelor of nursing degree at UBC.

Other recipients are Beverly O'Brien for baccalaureate studies toward a degree in science in nursing at UBC; Jennifer Stone, Mrs. Gayle Colonel, Mrs. Hilda Van Bergen, Mrs. Kathleen Lawley, and Gladys Anne Zitko, all diploma program students at UBC.

Carol Horton and Doris Ann Varco, basic nursing program students at UBC, have been awarded bursaries from the Margaret Sinn Fund, which is administered by RNABC.

New Roles For Social Workers

Ottawa. – Writing in *Canadian Welfare,* Brian Wharf, associate professor, McMaster University School of Social Work, said that social workers should be trained as advocates and reformers. He pointed out that the former roles of case worker, group worker, and community organization specialist are not enough to help people.

"Many students and professionals are becoming more and more disenchanted with the old idea of helping people to adjust to their environment," Dr. Wharf said, "and they are demanding that attention be given to changing the environment."

Professor Wharf's proposals for case workers and group workers are that, with their skills of diagnosis, interviewing techniques, and knowledge of community resources, they are ideally suited to identify needs in an area and therefore help in the development of new services.

Case workers should be advocates, because advocacy seeks to ensure that the existing system treats clients fairly, he believes. He supports the adoption of advocacy as a principle of practice to encourage the position of social worker as an ally of the people. "There is no doubt that we need radicals in residence who don't mind and even relish throwing the spotlight on gaps in service, on rigid rules and practices, on inadequate allowances and housing, and on comfortable professionals."

Dr. Wharf said social workers have a unique contribution to make because they are the only profession that reflects a total concern for all aspects of people in their social role. □



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dates

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November 19, 1969
Symposium of Operating Room Study Group of Manitoba in conjunction with the Manitoba Health Conference. Fort Garry Hotel, Winnipeg, Man. Contact: Mrs. Diane Aboud, Corresponding Secretary, St. Boniface General Hospital, St. Boniface, Manitoba.

November 19-21, 1969
2nd Manitoba Health conference, Fort Garry Hotel, Winnipeg, Manitoba. The theme of special sessions for November 20, planned by the Manitoba Association of Registered Nurses, is Community Health — Planning for Progress. Another special session topic will be Providing Continuity of Care — The Home Care Program: Community Or Hospital Based. For more information write: The Manitoba Association of Registered Nurses, 647 Broadway, Winnipeg 1, Manitoba.

November 24-27, 1969
Conference for directors of nursing, Toronto. Sponsored by Ontario Hospital Association and Registered Nurses' Association of Ontario.

November 24-28, 1969
Nurse educators' course on disaster nursing, Canadian Emergency Measures College, Arnprior, Ontario. Nurse educators from English-speaking schools of nursing are encouraged to enroll. Preference will be given to representatives from schools of nursing that have not incorporated disaster nursing in their student nurse curriculum. For further information write to the director of emergency health services in your provincial department of health.

November 25-28, 1969
Annual Convention, Alberta Hospital Association, Calgary, Alberta.

November 26-28, 1969
Fourth annual convention of the Canadian Society of Inhalation Therapy Technicians, Calgary. For information write: Mr. E. Zaiss, Convention Chairman, Rockyview Hospital, Calgary, Alta. ☐

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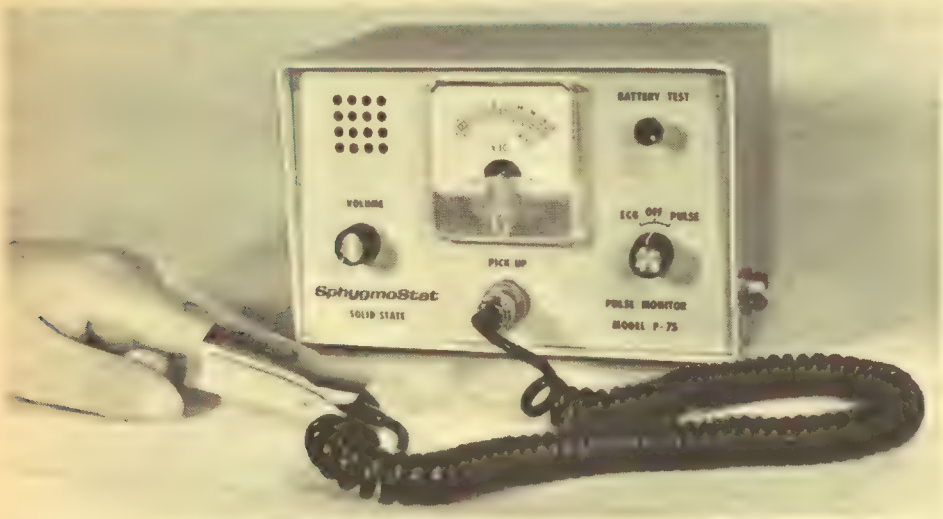
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new products

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CHA says president misquoted

An item in the September issue of *Canadian Hospital News,* published by the Canadian Hospital Association, states that *The Canadian Nurse* misquoted the president of CHA, L.R. Adshead, in a news item that appeared in the July issue of *CNJ.*

The news item, based on discussion at the CHA annual meeting in May, quoted Mr. Adshead as saying, "The CNA supposedly represents 80,000 nurses. The CNA is poppycock." According to *Canadian Hospital News,* Mr. Adshead did not say this:

"The argument raised during the discussion was that only the Canadian Nurses' Association, representing 80,000 nurses, could properly undertake such a study. To this President Adshead replied, 'Poppycock, this is an employer study of the graduates of the two and three-year programs. We want to know the quality of the product and how the hospital can assist to ensure both graduates achieve an equal level of performance.'"

Our reporter at this meeting wrote what she heard. We are, however, pleased to learn that Mr. Adshead apparently did not say that CNA is "poppycock." After all, the ultimate goal of both associations is to promote better patient care. To do this, we must work together, with mutual respect.

Psyche soother

Here are a few more good reasons why you should enjoy that glass (or two) of wine – although the pleasure principle alone is usually reason enough.

We quote a quote from an article in *Hospital Economics,* noted by the Wine Institute of San Francisco: "Wine soothes the psyche as it serves the heart, making it a most effective adjuvant in the treatment of cardiovascular disorders."

Dr. Salvatore Lucia, professor emeritus of the University of California School of Medicine, San Francisco, writes in this article that wine helps to open blood vessels; reduce the amount of cholesterol in the blood stream; quiet emotional tension; and can help the heart regulate its rate of beating.

The use of wine to treat heart disease dates back to at least the first century A.D., the author says. Because it dilates blood vessels, wine has long been used to treat poor circulation in fingers, toes, and other extremities. And doctors have even been able to prevent the need for amputation in gangrene, with the use of wine. For this reason, it has been recommended as a treatment for stroke.

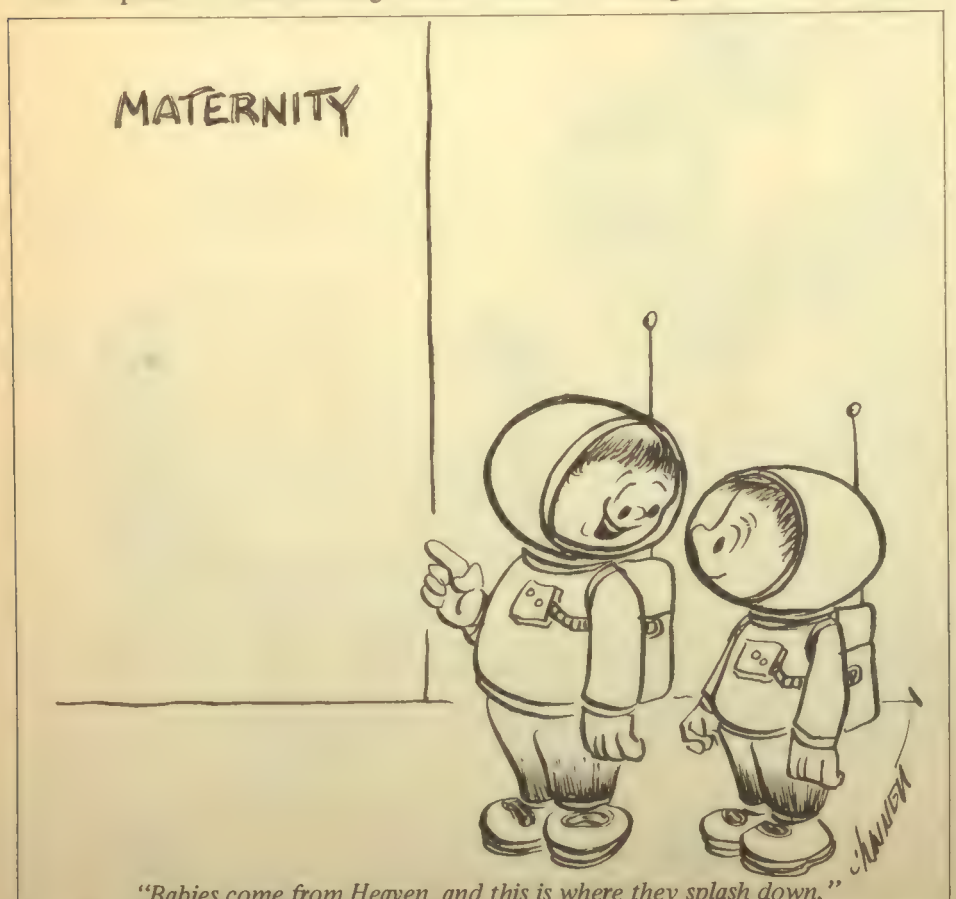
The fact that wine helps the heart by reducing emotional tension "cannot be too greatly emphasized," says Dr. Lucia. We heartily agree.

Dawdling don'ts

The Department of National Health and Welfare included the following advice in its July and August Health Notes.

Time means nothing to a young child. A lot of dawdling is actually concentration upon the thing most interesting at the moment, says the federal health department publication, "Up the Years From One To Six." A hungry child may become so fascinated by watching soap bubbles burst while washing his hands that it takes him ages to finish and come to his waiting dinner. He isn't purposely wasting his time. To him it's all part of the process of learning everything about everything.

Time does mean a lot to a busy mother. But a child can turn deaf to a torrent of words. And if you start prodding and scolding now, you'll be at it for a long time. If you're giving your child responsibility for his own eating, dressing, going to the toilet, and washing, and if he doesn't feel he's being bossed too much, he will gradually speed up. Dawdling for him won't become a form of passive resistance.



"Babies come from Heaven, and this is where they splash down."

Hospital Administration

There are procedures both common and special,
There are policies which apply to us all,
There are forms both in multi and single,
Oh how can I cope with them all?
Now committees work on them revising,
Reviewing, renewing all the while.
To delete one, because it's not used any more,
Guarantees it will come back in style.
There's a problem, it's common to all of us,
No memo's come through on it yet,
How can I remember which policies
Are the ones I'm supposed to forget? □

– Normina Brooks, Edmonton, Alta.



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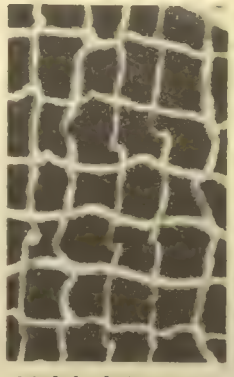
Gruelling knee-bend test shows why more hospitals use KLING Bandage every day

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Little hooks in KLING *bandage prevent slip*



After 50 bends, black line shows no movement

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On the delegation of responsibility...

The author conducted an experiment in self-evaluation with students and confirmed her belief that they can be responsible for their own learning.

J. Leith Nance

I wonder where and when nurse educators – or their predecessors by any other name – began to assume they were responsible for the education of the student.

Principles of management state clearly that although you can delegate duties, the responsibilities for those duties remain with the person who will carry them out. It follows, then, that teachers are responsible for teaching, students are responsible for learning, and patients are responsible for getting well. Isn't is logical to assume, further, that the teacher is responsible for continuous evaluation of her skills as a teacher, the student for evaluation of herself as a learner, and the patient for evaluation of his level of wellness?

Have you ever wondered why a patient will lie in pain while an intravenous solution slowly oozes into the tissues of his arm? Is it possible that nurses have implied they are responsible for assessing his level of comfort and that the patient, perhaps in this role for the first time, assumes this because of a lack of orientation to his role? Does the nurse usurp this responsibility because unwittingly she has relinquished her own?

Miss Nance, a graduate of Alberta Hospital, Ponoka, and McGill University School for Graduate Nurses, Montreal, is a Lecturer in psychiatric nursing at The University of Alberta School of Nursing.

Did our predecessors assume the responsibility for student learning solely because they were concerned with patient safety? Or did they do so, and do we still do so, because we fail to recognize that the responsibility to learn lies with the learner? When a person understands the scope of his responsibility and is reinforced in his attempts to assess his progress, he will strive to achieve the goals set – whether in regard to teaching, learning or getting well.

If we examine our own school of nursing experiences, most of us can identify times when we were frustrated to the point of anger by certain incongruities: we were held responsible for the welfare of a patient, yet were not considered responsible enough to determine our own social behavior in residence.

University schools of nursing have avoided some of the pitfalls of traditional diploma programs by expecting the student to assume responsibility for her own conduct. On the other hand, it appears that students in some baccalaureate programs are not given responsibility for their own learning. Faculty in these schools are so concerned about turning out a quality product that they push the learners, rather than guide them.

For example, each student is expected to read certain articles and books, perform procedures with at least minimal skill, and possess a specified amount of a particular type of predetermined know-



Four students examine the self-evaluation form they used to determine personal achievement.

ledge. She is seldom consulted about the course content. When she is consulted, she is so unprepared for this that she is unable to identify her own needs. The student identifies success in terms of a "successful" examination, a "successful" interview and a "successful" evaluation – not as personal growth and satisfaction. Students in most situations are required to write self-evaluation reports, but all too often their evaluation has little bearing on their final record.

As a result, the student does not have the responsibility for her own evaluation and feels no responsibility to live up to it. The instructor, having assumed this responsibility, must then take on the additional responsibility for the student's continued learning and safe conduct.

Why should the student reach out for a book that isn't on the list or offer to cut her patient's flowers or to help the kitchen maid clean up spilt milk? These things aren't part of the requirements for success! Why should she turn down a date in favor of an assignment or an opportunity to practice some technical skill, if success is measured by someone else, rather than by a personal feeling of pleasure, certainty or, better still, a hunger for more knowledge?

What happens when the student graduates? Too often she stops learning, develops methods of escape and avoidance, and becomes hypersensitive to criticism. Why should a graduate nurse attempt to read nursing journals and attend workshops unless she is told to do so? She has never before been required to make decisions concerning her education.

I was prompted to write this paper as a result of an experiment with third-year students in a four-year degree program. The experiment began after the students had completed a 13-week guided learning experience on an active treatment psychiatric unit. They increased their familiarity with the community through home visits, but still lacked an appreciation of the extent and severity of problems in the community that intensify emotional and intellectual disorders.

To increase this understanding, each student was asked to select one of 12 topics or to suggest a topic she would like to study in depth. The students were free to set their own objectives, determine their method of enquiry, go at their own speed, evaluate their gain, and determine their own score. They were asked to present their findings in their own way to the others in the class. We gave them a week to collect information, to plan for their presentation, and consult with us if they wished.

Preliminary discussion with the students elicited some resistance in the form of, "Well, I'd like to have some say in the final mark, but I'd be happier if you (the instructor) would mark me too so I could see how our marks compare." We countered this with, "Education is a growth process, and a personal one at that, hence we are ill-equipped to measure what you gain from the experience."

Students also suggested that the teacher was responsible for marking students. We replied that each individual is responsible for her own growth and goals and should likewise be responsible for her own assessment. We concluded the discussion by explaining that they would be responsible for living up to their evaluations. In the end they agreed to try it with the understanding that if they wanted to change their minds they could. No one did.

During their unstructured week they each worked independently – some diligently, some not so diligently. They arranged visits to agencies, industries, and businesses; visited homes; masqueraded as poor people; lived at an alcoholic rehabilitation hospital; got involved with teen groups; interviewed children and their parents; and other activities too numerous to mention.

The knowledge and understanding they conveyed to their instructors and peers were beyond our expectations. In every instance we learned more about each topic and its related problems than we could have hoped to present ourselves.

Marks for the experience were divided: 70 percent for the assignment and 30 percent for an oral examination. We assured the students that their final mark would not be questioned – whether it was 0 or 70 percent. The scores ranged from 48/70 to 64/70 with a mean of 56/70. A mean of 80 percent may seem high, but is not, in our opinion, out of line. But then our opinions don't count because the mark was based on personal growth! The only tool we have for the measurement of personal growth is the student herself – a tool which will get rusty if we don't use it.

What did the students say? We asked each of them to complete a questionnaire designed to elicit feelings concerning the assignment, what they found most valuable, least valuable, most anxiety provoking. The results, too lengthy to be enumerated here, were strongly positive. All agreed it was difficult; most said they applied themselves more to this task than to most assignments; and all found it a worthwhile experience that should be repeated in this area and developed in others. Only one student stated she would have been happier if the instructor had helped with the final mark and evaluation.

This experience confirms my belief that people usually live up to your expectations of them. They can and will assume responsibilities that are theirs to assume. □

The bluebirds who went over

In World War I, Canadian nursing sisters who served overseas were sent chiefly to France, Belgium, and England, but some of the first to volunteer found themselves in Cairo, Salonika, and the Isle of Lemnos. A few of these nurses talk to the author about their experiences as "Bluebirds" who went over.

Carlotta Hacker, M.A.



N/S Heath – now Mrs. W. MacDermott.

It was difficult to eat or drink without swallowing flies: the tables swarmed with them. When dressings were changed, a nurse had to stand by, fanning vigorously, to prevent the flies settling. Bandages were in short supply and often a soiled one had to be used again over a clean dressing. Then, back clouded the flies onto the bandage.

That was the picture in 1915 on the Isle of Lemnos, when two Canadian Stationary Hospitals were first landed to nurse the wounded from the Dardanelles. The temperature was 100°F. in the shade and, although medical supplies had been landed with the two Canadian units, they were not nearly adequate for the thousands of wounded and dying who had been brought to the island. Food was also scarce to begin with, and so was water until wells were sunk.

Miss Eleanor M. Charleson, who is now 95 and who was one of the matrons on Lemnos, recalls that when she first arrived on the island she and her nurses had nothing to eat except malted milk tablets. They existed on these, chewing them up drily, for something like two days. Then the *HMS Glory* came into harbor, saw the plight of the nurses, and brought in food and all the boiled water they could lay their hands on, rolling the heavy water drums up the craggy, steep hill to the camp.

"My nurses cried when they got the cold water," Miss Charleson recalls.

Over half a century has passed now since the War To End All Wars, yet a number of the 3,000 Canadian nurses who served overseas are still living. It is strange to talk with them and to hear, first-hand – vividly and simply stated – their personal anecdotes and their descriptions of events that long ago became history.

The nurses experienced terror and tragedies, yet not one of them considers herself a heroine. "There was a job to be done, so we did it," is the attitude. They state the tragedies as facts, long-accepted facts, and remember chiefly the purposefulness of the period, the team spirit that bound them together, and the happy times – an afternoon picnic at Boulogne, or a ridiculous fiasco about army etiquette, or the day a visitor was whisked off in an ambulance in mistake for a Portuguese soldier who had been found to have leprosy.

The Canadian nursing sisters served chiefly in France, Belgium, and England, although some of the first to volunteer found themselves in Cairo, Salonika, and the bare Isle of Lemnos. Because of the enthusiasm for the war effort and the fact that brothers, sons, and fiancés were all

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The author, a free-lance writer and researcher, is a frequent contributor to *The Canadian Nurse*. She and the editor express their appreciation to Miss Dorothy Percy, who first thought of the idea of writing about nurses in World War I and who subsequently helped to set up the interviews.



Nursing Sister Ethel Bagnall.

joining up, most of the girls had family approval for the step they were taking. However, Mrs. W.B. MacDermott (then Miss Miriam Heath) had strong family disapproval. Her father considered her application as no more than a fad and managed to block it. But, like so many other nurses, Mrs. MacDermott was determined to play her part; within a few months she had succeeded in becoming a nursing sister in the Canadian Army Medical Corps and was crossing the Atlantic on the *HMS Letitia.*

Matron Charleson, a graduate of St. Luke's, Ottawa, also experienced opposition from her father. She was one of the first to enlist, taking the opportunity when Margaret Macdonald, Matron-in-Chief of the Canadians, was in Ottawa in 1914. Miss Charleson went home to break the news to her father, who was then 80. The encounter is best described in her own words:

"I said to Father, 'If they'll take me, I'll go,' and he said, 'No, I don't want you to do that, Daughter.'

"But I said, 'Father, what would you do if you were my age and you had the profession that was most needed? ' . . .

"And he said, 'Well, I'd go.'"

So Miss Charleson went. By the time she returned to Canada after the war she had gathered a Mons Medal, a Mention in Dispatches, and a Royal Red Cross, First Class.

Matron Charleson first served with No. 1 Canadian Stationary Hospital on the Western Front. In 1915 a seasoned unit was required in the Near East because of the casualties in the Dardanelles, so she and her nurses were posted to the Greek island of Lemnos, only about 40 miles from the Turkish coast.

"A folly! I don't think they could ever have evacuated us in an emergency. The ships were already full."

She vividly remembers her arrival on Lemnos: the heat, the flies, the dust. The nurses landed wearing white shoes and stockings – which were dirty grey by the time they had trekked up the hill to the hospital site. The working uniform at the time was a blue dress, with white starched collar, but in that heat it wasn't long before the Canadian nursing sisters had removed their restricting collars and had slung their veils round their necks as more comfortable scarves.

"Trust the Canadian nurse to make herself look glamorous! " said Miss Charleson with a laugh. "But I didn't care. My idea was the comfort of my nurses. I'm very proud to say I never lost a nurse."

No. 3 Hospital, the other Canadian unit on Lemnos, suffered dreadfully from sickness among its staff, and the matron and one of the nurses both died of Asiatic cholera. They are buried there in the graveyard that also holds the bones of Rupert Brooke, the First War poet.

Much of the nursing on Lemnos was medical, for many of the ships of wounded went straight to the hospitals on the mainland of Egypt, so it was disease as much as wounds that the nurses had to overcome.

The hospitals consisted of tents, holding about 50 men each, and the nursing sisters – "Bluebirds" as they were nicknamed – lived in smaller tents. In addition to the flies, a considerable amount of wild life succeeded in crawling or flying into the tents – a centipede in the night scared Miss Charleson far more than German bombs ever did – and when the weather changed and the rains burst upon Lemnos, the rush of water rolled great boulders into the tents, and beds and patients were awash.

"It was a fitful climate," remarked Miss Charleson calmly.

However, toward the end of her time on the island the patients were moved into more weatherproof quarters as a result of some quick thinking on Miss Charleson's part. One afternoon, when Miss Charleson was out for a walk with Colonel McKee, the CO of No. 1 Stationary Hospital, they suddenly came upon some empty huts.

"Let's take them! " said the matron immediately. "Squatter's rights."

So they moved their hospital into the huts – much to the annoyance of an Australian medical unit that arrived some days later, and for whom the huts had been built!

After Lemnos, Matron Charleson was sent with her nurses to Salonika. Mrs. M.C. Lynch, formerly Miss Mary MacIntosh, was also at Salonika, having particularly applied to go there. Like Miss Charleson, she was an experienced nurse before the war, for she had graduated from St. Joseph's Hospital, Glace Bay, a good 10 years earlier.

Salonika was hot, very hot. Flies and mosquitoes abounded and dead donkeys were left to decay in the streets. Here the nurses were not too busy; in fact, for long stretches they had little to do but wait for a convoy.

"They also serve who only stand and wait," Matron Charleson told her nurses. "And that *only* should be left out because I know that the waiting is one of the hardest parts."

When convoys did arrive from the front, they brought chiefly patients with dysentery and malaria. Mrs. Lynch re-



Matron Eleanor M. Charleson

members that brandy was one of the chief medicaments given for malaria.

"And one day somebody got at the brandy and finished it all off."

Fortunately her brother-in-law had given her a flask of brandy when she joined up. She had forgotten about it until that moment, when it was hurriedly brought out and issued to the malarials.

As at Lemnos, food was scarce.

"We were hungry," states Miss Charleson simply.

Mrs. Lynch can remember margarine with streaks of green through it, and the staple food – such as it was – seems to have been cans of Australian rabbit.

On the Western Front, in France and Belgium, food was plentiful and the hospitals were well stocked. As in Lemnos and Salonika, the nurses often lived in tents, but most of the wards were huts, with 45 or 50 patients to a hut. However, these huts were not always newly built. Sometimes they were old barracks and, in bad weather, a nurse walking the wards in a raincoat might hear a plaintive cry:

"Sister! Will you move my bed a bit? It's raining on my feet."

No. 3 Canadian General Hospital at Boulogne, where Mrs. MacDermott served with the McGill unit, used the semi-ruins of an old abbey as well as some huts. In this antique setting, Mrs. MacDermott spent much of the war nursing Portuguese and Jamaicans (the latter suffering chiefly from pneumonia), for the Canadian nurses were not specifically attached to the Canadian Expeditionary Force: they nursed whatever nationality needed their services.

Even though the major hospitals in France were situated on the coast, away from the front line, here too the war was ever present. There were frequent attacks from the air. Mrs. W.A. Blue, a Canadian who served in France with the U.S. forces, can remember her alarm when she first saw observation balloons, for she thought they must be a fleet of zeppelins; and Miss Ethel Bagnall, a graduate of Montreal's Royal Victoria Hospital, still relives the horror of the many air raids she went through.

Her initial experience of bombs, as well as shellfire, was at the forces hospital at Ramsgate on the south coast of England, where they were regularly shelled from across the channel and sometimes bombed simultaneously. But that was only the beginning. In 1918 Miss Bagnall was stationed with No. 1 Canadian General Hospital at Etaples, on the French coast, during the terrible bombing raid that caused 170 hospital casulties in one night.



Matron Charleson (center, first row) with nurses on the Isle of Lemnos.

"We were bombed for two solid hours," she remembers. "We lost 60 orderlies and 3 Canadian nurses. I was on night duty and my ward was struck. Everything was riddled with shrapnel. And there was one tent that was just wiped out. The boys in it had arrived that day, so we didn't even know who they were."

After this experience she got her patients and herself under the beds at night when the planes came over. She finally conquered her fear of raids when she was moved to the front line in Belgium. There she found herself playing bridge with the colonel when the bombers came over, and the colonel wouldn't allow her to take cover under the table.

"So I sat down and continued the game of bridge, and after that I was never nervous of air raids again."

During air raids the nurses were often on duty far longer than their 12-hour shift. In a fairly light raid, some were permitted to sleep (if they could), but operating room nurses were expected to be on duty even if they had already worked their very full day.

"But the nurses never questioned that there was a duty to be done," said Matron Charleson. "You really cannot beat the Canadian Nurse."

It wasn't only during air raids that extra hours were needed and therefore worked. Mrs. MacDermott can remember being on duty at Boulogne for 72 hours at a stretch when a convoy of gassed soldiers arrived straight from the line.

"They were temporarily blinded," she said, "and the whole hospital was on duty day and night for two or three days. The treatment was boric acid and castor oil. And it cured them all! I don't think one of them went blind."

During a major offensive, or a retreat, convoys of wounded arrived continually. The nurses stayed in the wards until the casualties were cleaned up and until those who were well enough to travel further had been put on the ships to be taken across the Channel to hospitals in "Blighty." But even at comparatively quiet times the arrival of a convoy meant intensive work. Often the hospital staff was given little advance warning of a convoy and the nurses would have perhaps three hours to vacate as many as 150 beds and get them ready for the arriving casualties.

It was up to the doctors to decide which patients were well enough to travel, but Mrs. M.C. Macdonnell, who served in France with No. 2 Canadian General, can remember an occasion when she intentionally kept back two of her patients. They were well enough to move on to a convalescent hospital in England, but they had both been medical students before they enlisted for active service in the army, and were invaluable to Mrs. Macdonnell – helping her change dressings of wounded in a hospital which, at



Soldiers taking a few minutes of well deserved rest.

the time, was very short-staffed. So she told them to get into bed before the doctor came round. He entered the ward almost immediately and, while Mrs. Macdonnell was explaining that these two boys were far too ill to be moved, the doctor was looking at their boots, which they hadn't had time to remove and which were sticking out from under the covers.

"Much too ill," the doctor agreed. He also knew what good work these medical students were doing within the hospital.

Mrs. Macdonnell, a graduate of Victoria General Hospital in Halifax, went overseas because her doctor husband was posted abroad and she wanted to be near him. She says that she originally had no intention of joining up: it was only meeting Margaret Macdonald, the Canadian matron-in-chief, at a party in London that caused her to sign on as a nursing sister. Mrs. Macdonnell maintains that she had little choice: she was a nurse, she was in England, and the matron-in-chief desperately needed nurses. By the following day she was in the army and was rushing round London collecting uniform, trunk, and other necessities and marking them all: "Nursing Sister M.C. Macdonnell, Canadian Army Medical Corps."

In spite of this story, any lack of enthusiasm is hard to believe when one talks with Mrs. Macdonnell who is French-Canadian by birth and who even now, in her eighties, is bubbling with enthusiasm; it is also hard to believe when one considers that, in middle life, she volunteered to nurse a smallpox patient, who was one of her orderlies, and she was isolated with him for nearly three months before he fully recovered. She has the same attitude that Miss Charleson states so clearly when she says:

"I'm not a heroine. I haven't done anything that any woman wouldn't have done if she was of my profession."



Not all the "boys" were badly injured!

Mrs. Macdonnell took several months to recover from a wound she received during an air raid; but the war brought her a deeper wound that was far slower to heal: her husband succombed to one of the many deadly features of the Great War, the influenza epidemic, and died on Armistice Day.

Miss Bagnall had a similar tragedy. Although she survived influenza – though she weighed only 68 pounds when she returned to Canada – and survived bombs and shellfire, her fiancé, whom she met at Etaples, was killed in action.

Yet both these ladies remember chiefly the pleasant and amusing times they had overseas. Mrs. Macdonnell will tell a delightful saga of how she refused to curtsy to the Duke and Duchess of Connaught, when they were visiting the hospitals. Miss Bagnall still laughs when she recalls how, after the raid on Etaples, the nurses often slept in the woods for safety and how one morning they woke to find they had slept among a Chinese labor unit. There is a lot of merriment and a lot of nostalgia.

Mrs. MacDermott met her future husband on the ship crossing the Atlantic, so for her, too, the war is remembered with a degree of warm nostalgia. Like Mrs. Hagyard, a Hamilton graduate who served with No. 16 Canadian General and who also met her doctor husband during her service overseas, she can say: "It was a very happy time."

Yet the war years seem to have been good years for all the nurses, whatever the outcome.

"It was a marvellous, marvellous experience," Miss Charleson said. "I wouldn't have been without it. And you keep it with you all through life."

While remembering how happy they were and how often they laughed – though perhaps sometimes it was to hide their private fears – these ladies don't seem to recognize their own bravery. What they particularly remember, and all mentioned frequently, is the courage and spirit they witnessed in the troops. Mrs. Lynch synthesized this, when she said:

"When I think back, I think of the boys mostly. They were so cheerful, always ready with a joke, even when they knew they were dying."

And Miss Charleson is still stating what must have been the attitude that made the Canadian nurses so very popular:

"We were where we were when we were wanted. That doesn't mean to say we were heroines. But it certainly is something that any nurse would be proud of." □

Staff-line conflict in hospitals

Conflicts among hospital personnel are almost impossible to avoid. However, they occur with less frequency when lines of authority are well understood and are followed.

Margaret B. Delahanty, B.N.



We hear a great deal about delegating authority along with responsibility. However, certain responsibilities in an organization cannot be transferred. For example, the responsibilities of the chief executive, known in hospitals as executive director or administrator, are in this category. Vision, planning, and initiative – so necessary for the efficient functioning of the hospital – rest with the executive director. These responsibilities cannot be delegated to department heads or to anyone else who is not part of management.

The executive director cannot assign management responsibilities to the chief accountant; the latter is responsible only for his activities as chief accountant. Similarly, the functional responsibilities of the chief accountant cannot be delegated to the hospital cook or to anyone else. Department heads are responsible for what their employees in their departments do; however, they cannot avoid or delegate their own specific responsibilities.

Obviously a clear understanding of the locus of authority and responsibility is necessary if the hospital is to operate smoothly.

Line and staff responsibility

Some kinds of responsibility can be delegated from top to bottom. Such "line" responsibility is found throughout the hospital. For instance, the chief housekeeper delegates responsibilities to assistant housekeepers; the accountant has assistants who represent him; and the nursing supervisor has assistants who represent her. Throughout the hospital, assistants exercise delegated authority.

As well as this "line" responsibility in an organization, there is also "staff" responsibility. Applied to hospitals, this could refer to an expert, or recognized authority, who is called in to advise or assist management in some special matter. For example, a lawyer may be necessary to advise in legal matters; a decorator, in color schemes for patients' rooms; or a specialist in group dynamics, for consultation in group work on the wards. Although professionally responsible for the advice he gives, this "expert" is not in the "line" authority of the organization.

In each hospital, then, there is customarily a "line" of authority graded down from the top of the department. This

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Miss Delahanty, a graduate of the Toronto Western Hospital and The School for Graduate Nurses, McGill University, was awarded the Montreal Women's Personnel Association Prize for best essay by a woman student in 1969. This article is based on her essay.

The author acknowledges the assistance of Lorine Besel, Assistant Director of Nursing, Royal Victoria Hospital; K. Brady, Lecturer in Public Health Nursing, McGill University; and S. Goldenberg, Department of Economics, McGill University, Montreal.

ladder of authority also goes above the department head to the superior authority and to the public, who have certain authority as patients, or potential patients. There is also the "staff" type of control, in which the staff departments are advisory to the line executives or line departments. As well, there is "functional" control, consisting of the functional responsibilities of specialists, such as the chief engineer, and there is "committee" control.

Application of staff-line concept

In the hospital, the board of directors is the chief decision-maker. The advisory committee to the board is in a staff relationship with it, hence advises, but does not discipline.

The request for budget usually comes from the administrator, who is in a line relationship with the directors of the various hospital departments. The board of directors may believe it knows more about the budgetary needs of the hospital than the advisory committee, and may resent the advice given.

As decision maker, the board is in a position to tell the administrator what he can expect in the way of budgetary allowance. Conflict may result. The administrator may resent the board's decision, because he believes he knows more than the board about the hospital's budgetary needs as he confers directly with the heads of various departments on a regular basis. The board of directors, in turn, is pressed by the provincial government to cut costs.

A conflict between two department heads that cannot be resolved between them must go up the line to the administrator. Since department heads are in staff relationship and have no authority to discipline each other, the administrator makes the decision for them.

A case in point might be where the dietary department puts a notice on the wards saying that nurses can no longer drink morning coffee with patients. The nurses on the psychiatric ward consider it therapeutic to join the patients for coffee in the morning and are disconcerted by the notice. These nurses will probably notify their head nurse about the sign. She, in turn, will undoubtedly bring the matter to her supervisor, who will bring it to the attention of the director of nursing. The director of nursing will then probably confer with the director of the dietary department and ask why the sign was put up.

The director of nursing may agree that drinking coffee with patients has a therapeutic purpose and is a nursing function on the psychiatric ward. She may therefore be annoyed because she was not consulted about a decision that she believes affects nursing. The director of the dietary department may believe she can post signs regarding food and drink without consulting the nursing department, because food and drink are within her domain.

Hence, conflict results. Neither party has authority to discipline the other, but each believes the area in question is partly within her domain. The directors of the two departments have to go up their line of authority to the administrator of the hospital, who will make the final decision.

Within the nursing department, the director of nursing service, the director of nursing education, and the director of inservice education are in a staff relationship with one another; all are directly responsible to the director of nursing in a line relationship. However, conflict may arise. For example, the director of nursing service and the director of inservice education may have different ideas about the ongoing education of staff nurses. As a staff nurse, I have had the experience of one director telling me one thing concerning patient care, and the other telling me something different. One then said to the other, in my presence, "I hope I haven't contradicted you." Such conflicts should be resolved in private and not in the presence of the staff nurse.

If these directors cannot agree, they must go up the line of authority to the director of nursing who will, if necessary, make the decision. She has the authority to do this, but whether or not they perceive her as having this authority is another matter.

Other examples of conflict

The clinical instructor on a ward is in a line relationship with the department of nursing education, which can tell her what she should teach the students, and in a staff relationship with the head nurse. The head nurse cannot teach the students on the ward – that is the clinical instructor's job. But the head nurse, who is in a line relationship with the department of nursing service, is responsible for the care of patients on the ward.

The clinical instructor is also in a line relationship with the head nurse because she is responsible to her for the care of patients whom she – the instructor – has assigned to students. Therefore, if a student makes a mistake, the clinical instructor is responsible to the head nurse for the mistake. The staff relationship between head nurse and clinical instructor is shown when, together, they assign the patients whom the students will care for.

The clinical instructor is responsible for teaching students to give good patient care. She may believe she has a responsibility to discipline a staff nurse, who, in her opinion, is setting a poor example. The staff nurse, however, is under the department of nursing service. The clinical instructor must, therefore, go to the head nurse and tell her what she thinks of the staff nurse's patient care, even though she may feel like going directly to the staff nurse. The head nurse disciplines the staff nurse, if she sees fit.

Naturally, things do not always take place in this idealistic way and conflict frequently results. The clinical instructor often goes straight to the staff nurse, who may be resentful. She knows that the clinical instructor has no right to give her orders, because they are not in a line relationship.

The staff nurse is in a difficult position because she has a commitment to both

the clinical and administrative lines of authority. She is responsible to carry out the doctor's written orders for patients and she is under the line of authority of the director of nursing, that is, the administrative line of authority.

The doctor, on the other hand, is under the clinical line of authority, that is, the medical board. He may perceive his relationship with the nurse as a line relationship and she may perceive it as a staff relationship. Actually it *is* a staff relationship, though this is difficult for some doctors to accept. The way the nurse perceives her relationship with the doctor determines the way she will relate to him.

The goal of the staff nurse who is in charge of a ward on evening duty is to see that all patients on the *ward* receive good nursing care. The supervisor's goal is to see that all patients in the *hospital* receive this care. The supervisor may take some nurses from one ward and assign them to another ward that is short-staffed. The staff nurse may believe this reassignement interferes with her goal of safe patient care on her ward. The goals of the staff nurse and the supervisor are the same, but one is responsible for more patients. For this reason, each perceives the other as interfering with her goal.

The supervisor is in a line relationship with the staff nurse while the latter is on evening duty. But the supervisor may believe she does not know the ward as well as the staff nurse. She may therefore see her role as advisory rather than directory. The staff nurse may believe she knows more about what is actually taking place on the ward than the supervisor, and may also see the supervisor's role as advisory, even though, on the organizational chart, it is directory. As we have seen, it is the way in which each perceives the other's role that will influence her reactions to the other.

The head nurse is part of management in some hospitals. She has a responsibility to implement directives from the director of nursing, even though she may not agree with them. As well, she has a responsibility to her staff and patients. The head nurse is in a line relationship with her staff nurses, and can discipline them. She may choose to assume the helping role, and indeed may find it an effective way to get things done. At the same time both parties understand, or are supposed to understand, that she has authority to go back to the directing role.

Conflict may ensue if the staff nurse has a degree in nursing and the head nurse, who has authority over her, does not have a degree. In this situation, the staff nurse may feel she has the knowledge but not the title of head nurse, and may resent the head nurse's authority.

Liaison nurses, such as those from the Victorian Order of Nurses, are in a staff relationship with the director of nursing of the hospital where they are working and in a line relationship with the director of the VON. The director of nursing of the hospital cannot discipline the liaison nurse for poor relationships with her head nurses; she must go to the director of VON, with whom the liaison nurse is in a line relationship, and ask her to discipline the nurse. In actual practice, however, the head nurse often does discipline the liaison nurse.

Since line-staff conflict often leads to one person giving orders to another – when officially she is not permitted to do so – some think the line-staff distinction should be discontinued. Others believe that the concept of line-staff is essential to the proper organization of any enterprise.

Conclusion

Even though the objectives of the line relationship are in the long run the same as those of the staff organization, the concept of line-staff is often essential to clarify exactly who can give orders to whom. This is particularly true when a situation reaches a crisis. Then it is especially helpful to consult the organizational chart to see who has authority over whom – even though in day-to-day, non-crisis situations the strict concept of line-staff relations is almost impossible to observe and conflicts are difficult to avoid.

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Psoriasis — the stubborn malady

This common skin disease has continued to baffle dermatologists throughout the years. Its cause is unknown, and although treatment usually brings about a remission, exacerbations are frequent.

Alida Silverthorn, B.S.N.

Of the many skin diseases affecting man, psoriasis is perhaps the most frustrating — to patients and staff — if for no other reasons than it is extremely common, has an unknown etiology, and tends to recur, even after successful treatment.

Neither sex is immune to this noncontagious dermatological problem, although men seem to be affected more frequently than women. The disease can occur at any age, but most lesions present themselves between the ages of 10 and 50 years. Approximately 25 percent of persons with psoriasis have a family history of the disease.

The extent of an individual's psoriasis varies from a single, relatively untroublesome lesion to multiple lesions that require intensive treatment in hospital. In either case the person is justifiably disturbed by the appearance of this unsightly disease, and needs assurance that this malady will respond to treatment.

What is it?

Essentially, psoriasis is a disease of epidermal hyperplasia and is manifested clinically by excessive production of scale. This thickened epidermis may replace itself six or seven times more rapidly than the thinner epidermis of normal skin.

Individual lesions consist of well-circumscribed plaques of dry, scaly erythema. Generally chronic patches of psoriasis have thick scales, whereas the acute lesions tend to be more red, shiny, with less scale.

The scales are distinctive, having a silvery sheen and flaking off like pieces of mica when the surface is rubbed. If scale is gently removed by scraping, minute bleeding puncta are often noted (Auspitz sign).

Lesions may develop in a scratch mark, surgical incision, or skin test site (Koebner phenomenon). There is marked predilection for certain areas of the body, including scalp, regions over the elbows, knees, and lower part of the back; however other parts of the body are often affected and the disease may become generalized.

Psoriasis is extremely variable in its duration and course. A single lesion may persist for a lifetime or many lesions may be present, disappear, and recur. Some patients are never completely free of the disease, whereas others may experience long remissions. Most patients are better in summer, particularly if they expose their lesions to sunlight. When individual lesions disappear, they leave no scar. Attacks and exacerbations may be precipitated by emotional stress, infection in some other part of the body, injury to the skin, and pregnancy.

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Arthritis is a complication that accompanies psoriasis in 5 to 10 percent of patients; it may precede, follow, or occur at the same time as the psoriasis.[1] This complication resembles rheumatoid arthritis, but tests for the rheumatoid factor are usually negative.

Nail changes occur in the more severe cases of psoriasis. These include pitting, particularly in the fingernails; and ridging, with thick, horny material under the nail plate — found mostly in the toenails.[2] Pruritis is usually slight, but occasionally troublesome.

How psoriasis is treated

Individual patients vary in their response to different types of treatment, but on the whole therapy is usually satisfactory. External treatment, consisting of crude coal tar and ultraviolet light (Goeckerman therapy) has the most effect. Acute cases in which the lesions are widespread and inflammatory are treated with bland applications until the disease has ceased to erupt, at which time routine measures are started.

Local applications of cortisone creams or ointments, with Saran Wrap used for occlusive dressings, offer some relief. This is often a treatment of choice for home use.

Methotrexate, an antimitotic drug and folic acid antagonist, can have a dramatic effect in certain carefully-selected patients who have severe psoriasis that has



Application of occlusive dressing over previously applied steroid cream.



Foothills nursing student applies a steroid solution to psoriatic areas on the scalp.

not responded to other methods of treatment. The rationale is to reduce the mitotic activity of the psoriatic epidermis, which is responsible for the scaling. Another drug that interferes with normal cell division, 6 mercapto-purine, is used in some centers.

Goeckerman therapy

The Goeckerman regimen of crude coal tar applications to all skin areas followed by ultraviolet light radiation (UVL) is still the basic treatment for patients hospitalized with severe psoriasis. This therapy, as employed at Foothills Hospital in Calgary, Alberta, consists of applications of 5 percent crude coal tar in 'Vaseline' petroleum jelly to the entire skin two times daily, plus 0.25 percent Anthralin to the plaques only. The ointments are applied at bedtime after a shower is taken, and the affected area is thoroughly scrubbed with soap, water, and brush.

In the morning the excess tar is removed from the skin by wiping it with a gauze or cotton pad saturated in mineral oil. The patient takes a bath or shower, then goes to physiotherapy where he receives UVL. Two hours after UVL treatment, tar and Anthralin are again applied. The patient wears the same "Johnny" shirt and pyjama bottoms and uses the same bed linen for a week at a time.

Immediate or delayed complications from this therapy are infrequent. Most troublesome is the development of folliculitis in a few patients, but this reaction subsides promptly if the use of the tar is discontinued.

Psoriasis also responds to both tar and UVL therapy when each is administered separately. The benefit achieved when these treatments are employed together may be that the tar acts as a photosensitizer.

An average period of treatment is from 12 to 18 days. Generally, the longer the period of hospitalization, the greater the degree of clinical improvement. The Goeckerman regimen is not proposed as a cure for psoriasis.

Ultraviolet light therapy

Ultraviolet rays, when absorbed in the skin, cause chemical actions that result in irritation and destruction of cells. This causes liberation of the "H" substance, which produces the triple response in a similar manner to histamine: 1. dilatation of the capillaries; 2. dilatation of the arterioles; and 3. exudation of fluid into the tissues. Depending on the strength of irradiation, reddening of the skin to formation of blisters may result.

After several treatments of UVL, the patient may appear very sunburned, even to the point of blistering. Analgesics may be required for discomfort.

The initial erythema tolerance to UVL treatment can be determined by test dose which is read after eight hours. Factors that may alter the erythema response include increase in melanin pigmentation, increased thickness of the strateum corneum, and concentration of urocanic acid in the epidermis. A daily increase of 30 percent to 50 percent usually produces the desired intensity.

All affected parts of the body are treated, and individual large plaques are shielded from the normal skin. To mask the areas of good skin, we use a barrier cream of RV Plus (titanium oxide 30 percent in a petrolatum base).

In treating these patients, we use mercury arc lamps. Neon lamps or mercury arc lamps are common examples of light production by an electrical discharge through a gas or vapor. Mercury is a heavy metallic element, which is normally liquid. When in an electric arc, its electrons are easily raised to energy states that permit the emission of line spectrum with radiant energy concentrated mostly in the ultraviolet. Since mercury is comparatively inert and does not react appreciably with electrode materials or glass, it is ideally suited for use as a source of ultraviolet.

The pressure of mercury vapor in lamps is determined by the temperature. A low pressure of the order of 0.001 atmosphere in "cold quartz lamps" has a temperature of 60°C. In this lamp, the lines are very sharp and more than 90 percent of the energy is concentrated in

the two wavelengths, 2537 angstroms (Au.) and 1849 Au. wavelength. If otherwise transmitted, the 1849 Au. line is absorbed by oxygen in the air to form the toxic gases ozone and oxides of nitrogen. Since the 2537 Au. line is near the peak of maximal bactericidal activity, these lamps are ideal for the purpose of destroying the airborne and surface bacteria, viruses, yeasts, and molds.

Low pressure mercury lamps provide the basic requirements upon which the production of light by fluorescent lamps depends. The phenomenon of fluorescence is due to the fact that certain substances (phosphors) have the property of absorbing light of comparatively high frequencies and re-emitting it as light within a limited range of lower frequencies.

Through the proper selection and combination of various phosphors, it has been possible to develop a fluorescent sunlamp that radiates energy in the 2800 to 3500 Au. wavelength band. (In the fluorescent lamps employed for illumination, the 2537 Au. wavelength emitted by the low pressure mercury arc is turned into visible light by a fluorescent material that covers the inner surface of the lamp wall). Initial treatments for Goeckerman therapy may be started out by using a fluorescent lamp.

Ultraviolet light therapy. Note the barrier cream on the patient's leg. This is applied to exclude the normal skin areas.



Therapy usually successful

Following this regimen, the patient usually looks and feels considerably better. He needs the nurse's help in accepting his appearance and in realizing that he may have a recurrence of the disease. Usually he can face this when he realizes that intensive therapy in hospital will produce a remission.

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Aging and learning

Our youth-oriented western society seems to accept the idea that aging is accompanied by intellectual deterioration. There is evidence, however, that intellectual and manual skills may be learned and maintained well into old age.

Monica D. Angus, R.N., M.A.

Aging begins when a person has reached his growth potential, usually around 18 to 22 years. The process varies from person to person, but is universal and irreversible.

Our society generally assumes that as a person's physical performance slows down, his intellectual ability also deteriorates. However, there is now evidence that adults can learn as well and as easily as adolescents, given suitable conditions. These conditions can be discovered through a careful study of the adult, his physiology, and his society.

We do not know exactly how aging comes about. Most researchers in the human biological field agree that the potential duration of life probably is an inherited trait. Some believe this trait, possibly centered in one of the genes that govern the development of the metabolic process, determines which of us will experience the various aspects of the total process, and at what age.

To those concerned with adult learning and the bearing age has on learning, the theories of aging, although interesting, are not particularly important. The important concerns are the physiological changes that affect learning as the human organism passes maturity. Some of these can be established reasonably clearly, although many of their causes cannot. For example, we know that certain changes do occur with age in the eyes, bone, muscle, hair, ears, cells, and in the cholesterol level, sense of smell, respiratory adaptation, and physical activity of the individual. We know, too, that there is some dulling of the senses of tactile and painful stimuli as one grows older.

Physical changes

Some of the changes that take place are visible to the naked eye, others are not. We also must distinguish between the changes that are the result of aging and those that are the result of antecedent disease process. Once these distinctions are made, some attention can be given to those changes that have some bearing on the performance of the adult and his learning ability.

Changes in sensory organs, particularly the eye and the auditory apparatus, are significant to the older person's ability to learn. Both seeing and hearing become less acute with advancing age.

The eye, unlike many other organs, reaches full size early, at about two years of age. Changes in the eye begin about the age of 18 to 22. The eye appears to grow smaller as a person ages, because of loss of fat behind the eyeball. The lids tend to droop because of the inelasticity of skin of the folds above the eye. The color of the iris fades and the size and mobility of the pupil diminish.

The visual field gradually becomes smaller and the power of adaptation to dark is slowed. Farsightedness, or presbyopia, may appear in the fifth decade or later, but it is a universal affliction that comes with age as a result of inelasticity of the lens of the eye. Cataract and glaucoma, chief causes of blindness in old age, seem to have a hereditary base.

Welford concludes it is unlikely that optical defects of the eye are the sole cause of poorer differential sensitivity in older people.[1] He suggests that extended viewing time be given to adult students, and that the educator must be prepared to call the other senses into play when teaching adults.

Hearing also becomes less acute with age, although for most people no noticeable changes occur until after 40. Some believe that aging women lose hearing for low tones, however all data collected indicate that for both sexes aging brings mainly a loss of ability to hear high tones. There is evidence that changes in the receptor nerves of the inner ear are almost universal after 65.[2] No cure has been found for the loss resulting from these changes. High levels of noise have relatively little effect on hearing by people with nerve deafness; therefore older people may work better than persons with normal hearing in situations where

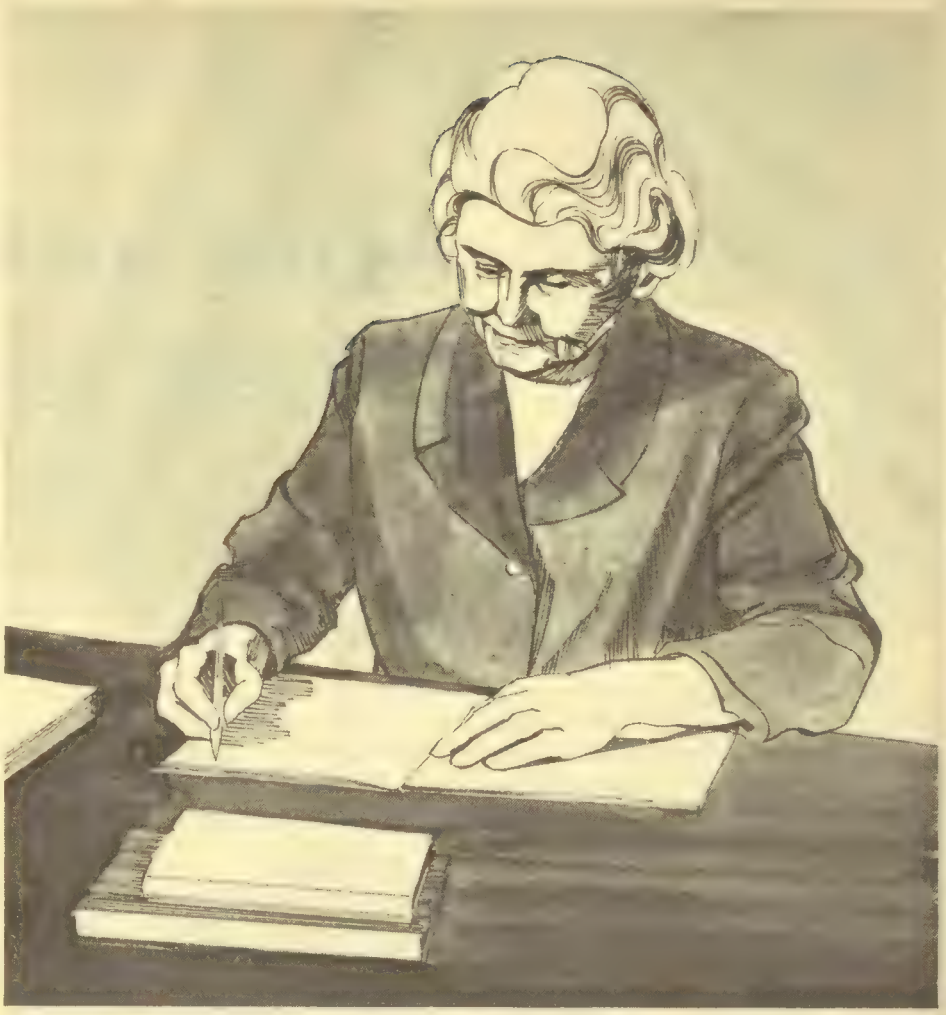
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the noise level is high.

Another possible factor affecting learning by adults is the "signal ratio," (the ratio of brain signals to noise level). This theory is that in middle and old age the number of functional brain cells is substantially reduced as many cells die and are replaced with non-nerve tissue, with subsequent decrease in the weight of the brain[3]. Obrist found a general lowering of activity and slowing of the dominant rhythms in electroencephalograms done on older people. There was, however, some increase in random activity. The conclusion drawn is that anything done to improve the signal to noise ratio will improve the performance of the older person, but not the younger person. Care must be taken, however, to insure that the subject's sensory mechanisms are not overloaded.

Much of the research suggests that illness and its consequences have a bearing on the adult's ability to learn. Older persons are much more subject to multiple chronic conditions than younger persons, and injuries that occurred earlier in life add a tremendous burden as age increases. Those concerned with the problems of the older person cannot help but be convinced that preventive health measures are of paramount importance.



Psychological factors of aging

The psychological factors of aging must also be taken into account. Justill proposes that the primary cause of the characteristic psychological changes associated with senescence – poor short-term memory, pronounced conservatism, diminished interest in new events, rigidity, reduced perception, and a good memory for distant events – lies in the progressive reduction in central excitability that occurs with age.[4] The consequence is a domination of past events over current behavior, together with marked limitations in the amount of information that can be handled by the brain. This does not mean that there will be any difference in the modes of thought.

Reminiscing in the older person has been found to be unrelated to the level of intellectual competence. Levin and Kahana believe that the function of reminiscing in the old is to shorten the span between the past and the present.[5] They point out that sick persons are not able to reminisce.

One of the accepted traits of adulthood is that as people grow older they become more rigid. Chown, however, claims that rigidity cannot be generalized from one situation to another because there are many components of rigidity.[6]

There are positive qualities of adult life or maturity to consider as well. The shift from adolescence to adulthood is supposed to bring with it greater emotional stability, more equilibrium in mood, more integration of ego processes, greater feelings of autonomy and stability, and greater extroversion. Cattell shows in his experiments that there is a consistent improvement in adjustment to life between ages 15 and 55,[7] and this view does not conflict with experiments done in the areas of man's view of himself. When asked, adults consistently say that 40 is the prime of life. We note all of these admirable qualities of adulthood, but our youth-oriented society's view of the aging person is not nearly as complimentary.

Some medical experts believe that various psychological factors, such as our negative view of older persons and their resulting loss of self-esteem, can have profound effects on the person's physical condition. This link between emotional illness and physical pathology suggests that psychological factors may speed up the rate of physical decline in older people. Certainly both physical pathology and psychopathology have a pronounced and detrimental effect on learning.

The suicide rate for older persons is evidence of this loss of self-esteem. There is a sharp inrease in suicide in middle age and a further increase with advancing age, the latter trend being more pronounced in men than in women. Although crude rates for suicide have decreased in most nations in the past 50 years, the rates for older persons, particularly women, have

increased. There has been no drop in these rates since government-sponsored welfare schemes for the aged have begun, suggesting that economic factors are not the only ones involved.

Data on suicide indicate that predisposing causes for suicide in the younger age groups were largely in the area of personal relations, particularly marital and family quarrels. These causes became less important in middle age, and much less so in old age. The opposite occurred in physical illness, which was judged by one researcher to have contributed to 35 percent of cases of suicide of the elderly. For older men, retirement seems to be an important causal factor in suicide, although for men of wealth it presents less of a problem. Presumably they go on to other hobbies and endeavors. The socioeconomic factor associated with retirement and suicide was apparent only for the lower income groups.

Learning by adults

Considering the diminished physical capacity of adults, is there a reduction in the adult's intellectual or cognitive performance? The evidence indicates a decline in speed and flexibility of comprehension, but no decline in the power to perform intellectual exercises. The formation of new associations is slower, but the power of reasoning and judgment, as well as the area of general information and vocabulary, do not decrease with age – in fact, there is evidence they increase.

Some intelligence tests given in adulthood indicate that, contrary to the findings of Terman and others,[8] intelligence does not decrease after 16 years of age, but rather increases.[9] However, the testers make it clear that researchers should not present conclusions about the growth of intelligence unless the type of intelligence and the method of measuring it is specified.

Speaking specifically of intellectual performance, Birren states: "One gathers from existing evidence that there is no gradual decline with age in general mental ability. The only aspect of mental performance that seems to change in most persons is that of slowing speed of response."[10] This researcher attempts to tie in intellectual functioning with survival in the older person. His expectation is that given good health and freedom from cerebrovascular disease and senile dementia, individuals can expect a high level of mental competence beyond the age of 80. All the evidence indicates that there is increasing variability among individuals with increasing age.

Reference is made repeatedly in the literature to the pacing of adults. There is considerable evidence that adults do not perform well on timed tests. They prefer to have time to mull over problems and weigh evidence before reaching a conclusion. However, when they perform on the basis of accurate completion, they do as well as, and sometimes better than, younger subjects. The implications for persons who teach adults should be obvious: adults must be given time to complete new tasks and must not be evaluated on the basis of speed of response. If this principle is followed, and provided the task is not beyond the capability of the subject, an adult's ability to learn should be as good as a young person's.

McGeoch and Irion postulated the theory that learning as a skill can itself be learned and maintained by continued exercise.[11] They believe the difficulties of learning by older people are due to disuse of this ability.

Interruptions in learning are also a hindrance to adults. Indications are that when learning a new skill, any disruption of the process will slow the performance of an older person, but not of a younger person. However, when an adult has acquired a particular skill, his performance at times may be greater than that of a younger person working at the same job, providing the job is not beyond his physical capability.

Educators should keep in mind that adults prefer to expand the sensory stimuli when dealing with objects. They need time to see, touch, smell, and hear.

Similarly, persons teaching adults should keep in mind the diminished eyesight and hearing of some adults. They should compensate by using large lettering on blackboards, speaking clearly, making full use of visual aids, and avoiding poor tapes, poor speakers, and, especially with elderly people, speakers with high-pitched voices.

Summary

The greatest problem that adult educators must deal with is the negative cultural view of aging in western society. All persons involved in teaching adults must have a realistic and positive view toward their students. When one considers that the years left to an individual after maturity are almost three-quarters of his life-span, and that the years of decline are long and protracted, it is easy to be optimistic about the adult's ability to learn. Scientific evidence indicates that adults who continue to use their intellectual and manual skills tend to preserve performance, and those who do not exercise these skills tend to lose their ability. Barring physical illness, the adult should be able to continue to learn until debility sets in. Clearly, there is a case for continuing adult education.

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The minis have it!

How micro-teaching was used to help prepare teachers of nursing.

E. Jean M. Hill, R.N., Ed.D.

At Queen's University, the fifth year of the baccalaureate program in nursing for post-RN students always has included practice teaching. The amount of experience, however, has varied from teaching one class in hygiene in a local high school to teaching several classes in a selected diploma school of nursing.

Because of the number of students and the location of the cooperating schools, little direct supervision has been provided by the university faculty. Although some of this practice teaching appeared valuable, the faculty in nursing believed that all planned learning experiences should be guided and evaluated by university teachers.

Most of our post-RN students anticipate appointments as junior instructors on graduation. As the spring term progresses, they become increasingly motivated to acquire technical skills in teaching and to acquire a little "know how." The faculty, too, want these students to develop a beginning competence in teaching. However, the heavy course load carried by students has made concurrent practice in teaching impractical.

Last year, a three-week workshop was proposed and a joint committee of faculty and student volunteers organized to plan it. The goal of the workshop was to develop confidence in the ability to select, organize, and present content in a small group or laboratory setting.

Since the workshop was to be student-centered, considerable responsibility was given to the student committee members. Initially, they compiled lists of desired activities from which the faculty helped them to state objectives in behavioral terms and to select experiences possible within the time available. A tentative guide for evaluation of teaching was composed by the faculty. Time was allocated from the class schedule to enable the student committee members to present their plans for the workshop to the total class; this presentation, well organized and enthusiastically given, elicited the desired support. At this point, examinations were imminent and the faculty assumed the administrative responsibility for implementing the plans.

Micro-teaching*

The McArthur College of Education at Queen's had been using micro-teaching in the preparation of teachers for elementary and secondary schools for some time. It seemed natural, therefore, to use a similar experience in preparing teachers for schools of nursing. With some assistance from College personnel, the students were able to use episodes or "mini-episodes" taken from the teaching plans they had developed during the spring term.

Financial aspects had to be considered too. Although some equipment could be borrowed without cost, the budget was insufficient to cover the expense of video-tapes and the salaries of technicians. Therefore, it was decided to use audio tapes only, and portable recorders were borrowed for each classroom. The usual classroom equipment was available and special equipment was borrowed as the need arose. A further modification was made in using classmates as learner-evaluators, rather than recruiting and paying students from diploma schools.

At this point, the class was divided into four groups, with six students in each group: one student-teacher, one process evaluator, and four participant learners. A faculty member in each group acted as consultant, resource person, adviser, and general morale booster. The groups were left intact throughout the three weeks while the faculty adviser rotated on schedule.

Each student taught one cycle of teach-reteach each week and each had one experience as process evaluator each week. Prior to each episode, the student-teacher gave her objectives for the episode and the level of the learner for whom the lesson was planned.

The cycle consisted of a 10- to 15-minute episode followed by a 20- to 30-minute evaluation conference with the learners, the student evaluator and the faculty advisor participating. The tape recordings were used diagnostically to identify the strengths as well as the weaknesses in the teaching process and the content organization. Suggestions for revision were made, then the student-teacher was given 30 minutes in which to restructure her presentation before reteaching the episode. The reteaching episode also was critically evaluated in the light of suggestions offered. The evaluation guide was used for both teaching and reteaching sessions.

The faculty advisers were impressed with the poise of the students during teaching episodes and the depth of involvement of the student-learners and evaluators. Although praise was given freely by classmates, analysis was made of factors contributing to both successful and unsuccessful teaching. It was not unsual to hear comments such as:

"Quite frankly, I don't know what you wanted from your question." "You mean, I didn't give you sufficient structure to answer that question? "

"Your introduction really set the stage for the lesson – it really got us involved."

"Listen to all those convergent questions – Don't you want to involve us in creative problem-solving? "

"Had you given us all that material in your lesson plan before the demonstrations, I'd have been bored."

With only 30 minutes for replanning, the amount of improvement demonstrated was gratifying.

Favorable reaction

The reaction of the students to the experience of micro-teaching was mixed, but generally favorable. They were tired at the end of the year and suffered from the let-down feeling that accompanies final examinations. They had feared boredom with reteaching the same content to

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*Micro-teaching, according to J. Fortune, J. Cooper, and D. Allen an article "The Stanford Summer Micro-Teaching Clinic, 1965" in *Teaching Methods and Materials* vol. XVIII, no. 4, Winter 1967, is: "a scaled-down teaching encounter... developed at Stanford University to serve three purposes: 1. as preliminary experience and practice in teaching; 2. as a research vehicle to explore training effects under controlled conditions; and 3. as an in-service training instrument for experienced teachers. In micro-teaching, the trainees are exposed to the variables in classroom teaching without being overwhelmed by the complexity of the situation. They are required to teach brief lessons . . . to a small group of pupils . . . . These brief lessons allow opportunity for intense supervision, video-tape recording for immediate feedback, and the collection and utilization of student feedback."

the same learners, but this did not occur until the third week. Students expressed pleasure in the self-confidence they gained through the experience; they looked like teachers to their classmates and it was possible for them to see themselves as successful in a role they both desired and feared. The anxieties and qualms so apparent to the individual were not recognized by their classmates. The trust developed within the small group enabled the student-teachers to be innovative.

Perhaps the greatest value lay in the immediate feedback. "You taught your lesson and the evaluation occurred." "The mini-episode facilitated review and remodeling. It was easier to cope with a 15-minute episode than a total class, yet the insight gained might enable one to undertake the more complex activity."

The concrete experience in the teaching workshop seemed to crystallize the theory studied during the academic year. Students found that the workshop sharpened their perception of the teaching process; they developed a way of looking at it, of analyzing and identifying acts that were successful or unsuccessful. The probability of transfer to full-scale team planning and teaching was discussed.

Suggestions for the future were freely offered. It might have been more effective to space practice over the spring term rather than concentrate it into a few weeks. On the other hand, a workshop eliminates the distractions of other course requirements. Since the workshop activities were not graded, students felt free to experiment, and anxieties about success or failure were reduced. If the practice were part of the course, this value might be lost. The concentrated experience in small groups seemed to contribute to the development of trust among class members, which enabled them to offer and accept critical evaluation as a means of promoting growth.

Was it worth while? The students and faculty agreed wholeheartedly as to the value of the experience. It had been exhausting but stimulating, and students felt they could face the future with a greater degree of confidence. Although practice with teaching whole lessons would have increased the preparedness of students, episode teaching had distinct advantages over the previous practice. In our opinion the minis have it!

Reaction of students who helped plan workshop at Queen's...

Jane Kirkpatrick

To understand our feelings as students participating in the student-faculty planning committee of the teaching workshop, it is necessary to know something of the teacher-learner working relationship that developed during the school year.

From the beginning we were encouraged to express our own ideas on education. The first question we were asked was, "What do you expect to learn from this course?" Much of the course was then designed on the basis of our expectations.

At first we were frustrated by this permissive atmosphere. It seemed we lacked direction from our teachers and had no inner resources to establish that direction for ourselves. To alleviate these feelings, some students grouped together to set up a student-faculty committee "to establish an efficient and organized channel of communication between the faculty and students to promote optimum learning."

Matters of student concern regarding curriculum, student opinions, and ideas were channeled to this committee and discussed at length. Student members freely expressed their ideas and the faculty advisors accepted and used these ideas when planning their classes. The workshop and its committee, therefore, had a strong background for the subsequent working relationship between faculty and students.

It is difficult to summarize our reactions to our involvement in the workshop planning, since this was such a personal experience for the six of us on the committee. We all experienced a change in our feelings, however, a change that reflected itself in our mounting enthusiasm.

We were motivated to volunteer as student members of this committee by our increasing need to acquire some practical skills in the application of our educational theory and to gain an understanding of how to plan a workshop. By participating, we hoped to gain in our personal development and to overcome some of our discontent with the theoretical orientation of the course.

During our first sessions with the dean and faculty members, we felt constrained to silence. This planning committee seemed only a nominal one and what we said was dominated by our instructors' ideas. It was a two-way fault: our inability to decide and express clearly what we wanted as students, and their inability to understand our unstructured ideas.

This carried on for several weeks to the point that our frustration, anxiety, and hostility drove us to create a tentative plan. Our vacillating at the beginning may have been due to our unclear goals for the workshop. Although we resented faculty domination, we wanted more concrete guidance on how to set up objectives and plan activities.

Despite the pressure of final exams, the end of term, and lack of subsequent time to devote to the planning, we finally put our ideas into a tentative outline. We hoped that this plan would be acceptable to our classmates and to the faculty. To our surprise, it was adopted with little opposition. At this point our planning efforts ended, and faculty members were left to implement some of the ideas.

Following exams and throughout the workshop itself, the planning continued. Committee meetings were more relaxed and we felt confident about expressing our own ideas. Most of the offerings seemed to come from us, but at the same time we did not reject faculty ideas. Finally, our plans and ideas crystallized into the workshop.

Being a part of this workshop in its planning stages and as participating students, we felt capable to evaluate it and refine the plans. The other students seemed to appreciate our efforts and openly expressed their ideas in class as well.

From this experience we developed insight into ourselves as we learned to assume responsibility, a working knowledge of planning a workshop, and an understanding of how to work with others. Above all we became more confident about our ability to express our own ideas and to function within nursing education. □

Two-year-old Michael — ill and in hospital

The pediatric ward has many faces: a swollen, tear-streaked face staring wide-eyed from behind the crib bars; a blank, unsmiling face withdrawn to a corner of the crib; a smilingly invulnerable face bouncing about the playroom. Almost every child in hospital is one of these faces during his stay. Why? Is this pain of separation, loneliness and fear necessary? What mark does it leave on a child and his parents after discharge?

Robin Burnie

During a follow-up visit to the home of a two-year-old I had cared for in hospital, his mother commented to me: "If you had walked in the door wearing a white uniform, I'm sure Michael would have run in the opposite direction." This statement is revealing: how does a two-year-old perceive a nurse? Are we nurses doing everything within our power to lessen the trauma of hospitalization?

Michael was admitted to hospital with difficulty in breathing and an elevated temperature. From his admission records, I noticed that auscultation revealed a marked decrease in air entry over the complete right chest. Concordantly, admission chest x-rays showed an area of consolidation involving the right middle lobe. All facts pointed toward a provisional diagnosis of obstructive emphysema due to aspiration of a foreign body. On admission, it was learned that he had been chewing peanuts just prior to his respiratory difficulty. Michael had probably choked on the peanut and it had become lodged in his right bronchus.

Nursing care consisted of close observation of respirations and vital signs. The day following admission, Michael showed signs of pneumonitis, characterized by a continued elevated temperature, nasal discharge, and persistent cough. Blood tests indicated an elevation in sedimentation rate and white blood cell count. A bronchoscopy to remove the peanut was done. It was on the day following this treatment that I first met Michael.

What a mournful looking little boy! He sat at the far end of his crib, hugging one of the rails. He was covered from head to toe in cereal, and his eyes were caked with "sleepy-dust." He was looking around and seemed to be wondering why the other children were getting washed while he was being ignored.

I sensed that Michael's emotional needs at this point far exceeded his physical needs. He needed someone to hold, someone to comfort him; he needed his mother, but she did not come when he called. Michael was alone in a strange world where he was locked into a crib and people pushed and poked and hurt him; he could not understand why. The way in which Michael dealt with the stress of hospitalization could determine his future response to stress in general.[1] Would he conquer it or would it conquer him?

There had been a sequence of separations that compounded Michael's hurt. His parents had gone away for a few days and had left him with a friend. Just after they returned, Michael had to be hospitalized. They could not find time to visit him often because they lived some distance from the hospital. They had two other small children, and Mr. D. worked late hours. Once, when they did manage to visit Michael, they arrived 10 minutes past visiting hours and were not allowed to see him.

Small wonder Michael's world of love and security had collapsed. His trust had been betrayed and he mourned deeply for his mother. Withdrawal, rejection, and apathy became his defense mechanism as he began to adjust to this new situation.

I realized that Michael was emotionally and physically drained. It was up to me to give to him and to expect little in return. By being with him as much as possible, by withholding my desire to reach out and hold him, by waiting until he reached out to me for comfort, I hoped to bridge this gap in the trust that was so essential for his future growth and development.

On his own terms

I tried to meet Michael on his own terms. At first I did not touch him, but merely talked to him, giving him time to adjust to a new face, a new voice, a new intruder. He said nothing and ignored me. When I bathed him, he responded mechanically. But when I changed his diaper his legs shot straight up. I had found an act that provided comfort; it was a familiar ritual associated with the memory of Mommy, warmth, dryness, and cuddling. It was at this moment that I realized how little I knew about Michael.

How I wished that there was background information on his chart! Did Michael dress himself, feed himself, talk?

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Was he toilet trained? Was the dog in his crib his favorite toy? So many questions were unanswered and each one could have helped me to help Michael. As it was, observations were my only guide.

During that first morning I observed many situations characterized by Michael's seeming depression. When he sat with the other children in front of the television, he was a passive observer. When I took him for his x-ray, he sat in his wheelchair tightly hugging his dog, ignoring approaches by the personnel. All these people came and went; there was no constant person to unify his experiences. They asked Michael to give of himself, but then they left him, just like Mommy had done.

I tried to counteract this negative force by taking a long time in bathing Michael that morning, playing "peek-a-boo" and other games. At refreshment time I helped Michael drink his juice and then suggested we color a bunny rabbit on the paper cup. Michael sat on my lap while we colored. When the medication nurse came to give him a tuberculin test needle, he stayed on my lap, and I held him until he seemed to have forgotten the hurt. Later, I held him for his chest x-rays.

It was on our return from the x-ray department that Michael spotted his mother, grandmother, brother and sister sitting in the hallway outside the ward. His face lit up. I suggested we go to his crib, but I made the mistake of turning the wheelchair away from his mother. Michael reacted to this visual separation by screaming. I took him from his chair and Mrs. D. carried him to his crib. She held him close and he cried quietly, expressing all his pent-up emotions in the security of his mother's arms.

Mrs. D. seemed bewildered by Michael's reaction. She told me that he talked non-stop at home: "I've never seen him like this before – so quiet – it's like the end of the world has come." I hoped that by talking with her I could help Mrs. D. feel more relaxed and make the present experience less cold and frightening. I explained to her that this was his way of adjusting to hospitalization; that it was a normal defense mechanism used by many children in adapting to stressful situations.

Meeting Michael's mother was beneficial to both of us because, in turn, Mrs. D. was able to give me some details about Michael at home. I learned that he talked in sentences; he was outgoing; that his toy dog's name was Poochy. If there had been a more suitable place to talk, I'm sure we could have discussed many more things.

Also, I think Michael was confused by having his brother and sister in sight, without being able to play with them. They are both close to Michael's age and are constant companions at home. A meeting with them would have been healthier for the whole family.

What a change in Michael the following day! It was as though he had read a book on separation anxiety and was following the expected pattern of adjustment. When I first noticed him, he was sitting in his crib with his bib on, and he was smiling. He set to his breakfast readily, accepting any help given with a smile. He was responsible to every act and to every person. When spoken to, he looked right at the person speaking, not avoiding them as before. When the cleaning lady asked him to hold out his foot, he stuck it out of the crib and giggled.

Some psychologists theorize that this change from depression to apparent interest and joy in surroundings is another phase of a child's response to hospitalization.[2] Since Michael could no longer tolerate the poignancy of his distress, he apparently was repressing all feeling for his mother. This could be true, for it agreed with what Mrs. D. later told me. She said that the last few times she had visited, Michael had said, "no, no, no," and ignored her. At any rate, Michael was gaining in strength and could now begin to interact with his environment.

Limited by illness

Michael's world was greatly limited by his illness. He was confined to his crib for most of the day and was only allowed up when his bed was being made. It was during these short times that I was able to see Michael at play along with other children his own age. Whether coloring or playing with blocks, they sat at the same table, each engrossed in his own play, so typical of the two-year-old. They had not yet reached the age of social play.

Because of his limited environment, Michael's innate desire to explore and discover was cramped. He needed help to be stimulated. I would bring him blocks and crayons and paper, and then sit with him while he played. He had mastered all of the motor skills characteristic of a two-year-old.[3] I saw him make fine precise movements in putting small blocks together and holding a crayon. He turned pages of his farm book one at a time and identified the animals within it. He built towers of blocks of three, filled a cup with these blocks, and then hurled the cup. He showed coordination when eating.

It was at mealtime that I was particularly struck by Michael's independence. He knew what he wanted and when he wanted it. He would eat his food eagerly, but would eat no more than he wanted. Then he would push his tray aside and lie down for his nap. By doing these things he was still able to exercise his developing sense of autonomy. Without such oppor-

tunities he would have been very frustrated.

As Michael became more secure, he showed his independence more and more. For instance, one day he did not want his bath, and responded to the bath by shouting "Don't! " However, by turning it into a game, we soon became friends again.

"Don't! " was a frequently-used word in Michael's vocabulary, along with "no, no, no." This negativistic stage is common to two-year-olds.

Michael had quite an extensive vocabulary. It consisted mainly of nouns, verbs, and adjectives used separately or together to express an entire thought. For example, when he wanted me to pick him up, he would say "Me up! " We worked together on building his vocabulary. I would carry Michael to the window and when he pointed at something outside I would tell him what it was and he would repeat it. This was his way of learning to enunciate and to make new associations.

Michael was a responsive, but quiet little boy when feeling physically well. However, at the first indication of stress he would withdraw into himself for comfort. This seemed to be his developed way of dealing with stressful situations. It was best, I found, to respect this and to leave him alone, because efforts to comfort him led to frustration and complicated the situation. During the acute phases of his illness it was particularly difficult to provide comfort for this child.

Ups and downs

Michael experienced several ups and downs during the course of his illness. Successive chest x-rays following the bronchoscopy pointed to progressive obstructive emphysema and finally to atelectasis of the entire right middle lobe. One week following admission, he awoke from his nap in obvious respiratory distress. His expirations were grunting and I noted chest retractions. He had changed so quickly from feeling well to feeling sick – an alarming ability of children and typical for progressive respiratory involvement.

I gave Michael an ordered suppository for his elevated temperature and notified his doctor. A repeat bronchoscopy was done. A second half of the peanut, surrounded by pus, was found lodged in the opening of the right bronchus. It obstructed in such a way as to allow air to enter but acted as a valve in preventing the outward flow of air. This accounted for Michael's normal inspirations yet grunting expirations. The peanut was removed, the pus aspirated, and Michael recovered rapidly following this final bronchoscopy.

Michael had one further upsetting incident when he vomited over his beloved Poochy. He cried whenever Poochy was brought near. I tried to help him by pretending Poochy had been sick and by coaxing him to help me help Poochy get better. First, we washed him, dried him with Michael's towel, and put him to dry in the window where he could still see him. Later, when Poochy had dried out, I gave Michael his talcum powder and he took great joy in putting it on the toy. This form of play therapy helped him to work out his adverse emotions.

I also found that Michael could work out these overwhelming feelings on a peg and hammer bench. The force with which he hit the pegs was amazing! This play served two purposes: he could take out all the hurt that he felt on it, and it acted as a type of "peek-a-boo" game. It gave him some sense of permanence – what disappeared did come back. He was also able to exercise some degree of control over his environment.

I feel that in nursing Michael I acted in a role parallel to these pegs. I cared for him, I left him, but I always came back. This was a stable influence in an otherwise fragmented experience. One nurse commented: "Michael has adjusted so well. I only hope that he adjusts as well to being home again." What happens to a sick child and what does not happen to him determines, to a great extent, the nature of his behavior, not only in hospital but for a long time after he has returned home. I had the opportunity to see this myself.

Follow-up visit

A few days after Michael's discharge, I visited him at home. How he had changed! He had thrived in the warm, familiar surroundings. Now I understood what he had missed in the hospital. There was Joey the goldfish and Billy the Budgie; there was his pet dog and his bunk bed. The house was small and everything about it exuded comfort, freedom, and happiness.

When I first arrived, Michael was in his high chair eating, and his brother and sister were near him at the kitchen table. Michael grinned shyly, in contrast to his siblings' boisterous welcome. They bounced from top bunk to floor to me, full of fun and energy. Mrs. D. tried to tame them, but to no avail, so she turned to Michael instead. She told him to eat up and he slipped out of the chair and joined us. At first he stayed close to his mother, but it did not take long for him to respond to the others' antics.

Michael was just as rough in his play as they were and he fought for what he wanted. At one point they were fighting over a stuffed giraffe. His sister tore it away from Michael and he hit her as hard as he could. Then he climbed to the top bunk. It was obvious that Mrs. D. was worried about Michael's safety, but she did not stop him. When he reached the top, he started to cry because he could not get down again. His mother picked him up, hugged him, and sent him on his way with a pat on the bottom. It was easy to see why Michael was so independent.

From Mrs. D. I learned that it was only in the past few days that Michael's behavior had returned to normal. She described how the hospital experience had changed him and in the course of doing so expressed many of her fears.

She said that before Michael was hospitalized he used to sit and eat all day; now he refused to eat and had lost weight. She felt perhaps he did not like the food at home as well as the hospital food. I suggested that perhaps Michael was not hungry at present. He was too wound up in playing with his dog and his toys and too excited by being home again. It is also natural for a two-year-old to lose interest in eating when there is so much of the world about him to discover.

Mrs. D. said that Michael was aloof at times. Whereas he used to be friendly and greet her with "Hi! Mommy" every morning, now he would bite and kick her for no reason at all. I explained the feelings that Michael had experienced during hospitalization. He was too young to understand why she had left him. He had felt deserted. He still loved her as much as before, but this was his way of telling her that she had hurt him deeply. He would soon forget and return to his loving self.

Michael's sleeping habits had also changed. Before hospitalization he was eager to go to bed when told, but now he refused to sleep in his own bed and wanted to be with Mommy and Daddy. The D's understood Michael's fears of loneliness and separation and his need to be close to them.

Michael had been toilet trained and had regressed in this habit during his stay in hospital. Mrs. D. did not find this a problem, and assisted Michael in a gradual return to his previous schedule. This problem might have been avoided if Michael had been encouraged to use the toilet in hospital. However, information about his toilet training was lacking

during his hospital stay.

When Mr. D. came home from work Michael was overjoyed and greeted him with a big "Hi! " Mr. D. picked him up and swung him around, indicative of Michael's close relationship with his parents.

Mr. D. said that he had missed Michael, too: "It's kind of hard on us you know, because no one has ever been sick before, let alone in hospital. When they went after that second peanut we gave up hope. Michael was in hospital longer than we ever expected."

Michael's father had enough confidence in me to share these feelings. By listening, I was helping. The parents also expressed feelings of guilt because they had not been able to visit Michael often. The D's felt Michael had rejected them because of this. I related Michael's rejection of them to this general pattern of reaction and adjustment. Mr. and Mrs. D. were relieved to see that it had been a necessary defense tool.

From this home visit I realized that the D's were warm, responsive, giving persons and parents, providing Michael with the security he needed for his growth and development. Seeing Michael cuddling Poochy on the floor, made me think of the times that I had seen him so unhappy, so lost. What could be done to make the hospital a happier place for other Michaels?

Suggestions

A family participation unit where rooming-in facilities for child, mother, and close relatives are provided would ease the strain on both parents and child.[3] Siblings of all ages should be welcome visitors. Studies have shown that chances of cross infection through such a unit are negligible. In this unit the mother would carry out the treatments under supervision and would take care of her child as she would at home. Visiting hours would be unrestricted.

In a case such as Michael's, where parents are unable to visit often, I believe that it would be beneficial to assign the child to the same nurses to gain his trust and lessen his anxiety. They could provide in part the love and security that his mother would normally give. In this way his relationships in hospital would be less fragmented and there would be some degree of unity in his day-to-day experience.

Inservice education is needed to teach personnel how to help the child emotionally. A head nurse who has been trained in the psychological aspects of nursing care could train her staff nurses and aides by example. She could encourage them to rock their children as part of their daily nursing care.

I have worked on two contrasting wards. On one, we were told not to pick the child up any more than required as it would spoil him; on the other, the head nurse herself would pick a child up if she had time. The latter ward was a far more enjoyable and relaxing ward to work on, and the children benefited accordingly.

An extensive admission history is necessary. This should include the degree of toilet training, feeding and sleeping habits, favorite foods, favorite games, pet names, vocabulary. By knowing these things nurses could help a child feel more at home and, at the same time, encourage an onward process of growth and development.

The nursing care plan on the Kardex could be more geared toward the specific nursing problem at hand. As Michael got better he needed more activity. The care-plan needed updating and filling-in. Special needs of the child and much of the admission information could be included in it. The Kardex should and could be an effective nursing tool.

Effective team conferences are needed. This is related to many of the above points. These should involve more than a mere report. If there is a specific problem in the care of a patient, the team should discuss it as a group and each member contribute ideas as to how to cope with the problem. It could serve as a channel through which doctors and nurses could exchange questions and answers.

Lounging facilities for parents could encourage nurses to talk to parents and help them understand exactly what is happening to their child. Visual aids would be of help in teaching parents. Comfortable chairs and the facilities with which to make coffee would give this room a warm and relaxed atmosphere. Here, the parents and nurse could give and take, and learn.

Extended play facilities with prepared staff would help children adapt to hospital living. The play therapist could attend team conferences and suggest to the staff toys that are most suitable for a specific child in a specific situation. For instance, she could suggest that a peg and hammer bench, such as Michael used, would help a two-year-old vent his frustrations. Illustrated posters with the same theme could be hung over the toy box or in the playroom.

During a follow-up home visit, I was able to help Michael's parents sort out many fears and questions. Other parents must have similar worries after their child has been discharged from hospital. Could interested nurses be given the freedom to visit in the home after a child's discharge? This would round out the nursing team and extend the continuity of care into the home.

Michael gave much else. He is now the model by which I assess other children's stage of growth and development and their corresponding needs. I learned to look beyond physical needs to emotional needs and to coordinate the two. I learned to include the family in my nursing care. Michael helped me expand my concept of nursing and, in turn, I was able to help him deal with the loneliness and pain that colored a small but significant part of his life.

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COMMENT

Quality of care makes the difference

Carol J. Matthews

In my job as a psychiatric caseworker I have often heard patients speak both positively and negatively of the nursing care they received while in hospital, and have been struck by the significant part it plays in the patient's overall attitude toward the hospital and his treatment. Recently, while in hospital to deliver my baby, I noticed how great indeed is the nurse's role in reassuring a patient, and how great the variation in the quality of nursing care given by different nurses.

From conversations with other mothers, I learned that I was not unique in feeling that I was about to do something quite exceptional and that everyone must be very impressed with me. It is my thesis that this feeling is what takes the edge off labor pains, and that the nurse can play a most important role in supporting and sustaining the mother's sense of self-importance.

I went into hospital at 9:00 a.m., and throughout the morning I was impressed with the cheerful, competent, and supportive manner of the several nurses who were in and out of my room. However, I had no clear idea of any one of them as "my" nurse. I believe patients would appreciate it if a nurse introduced herself as "your nurse, Miss X." It is frustrating to ask a question of one nurse and be told that you must ask your own nurse, when you don't know whom your own nurse is.

I found the daytime of my labor very cheerful. I had a lot of attention, with visits from my doctor, the nurse who prepped me, the receptionist taking admission information, and many others. A particularly important visit was that of the nursing instructor who came to ask if I would like her to assign a student nurse to me as a "mother-baby" nurse, and who spent some time telling me about the care both the baby and I would receive. Her visit made the baby seem a reality, and greatly increased my excitement and anticipation. My husband, too, was with me all this time and shared my feelings of enthusiasm.

My contractions were becoming more definite by the time the shifts changed and my new nurse arrived, and although I was suffering from little discomfort, I was reassured by the time and interest she gave me. When my husband had to leave for a few hours, the nurse stayed with me almost constantly until his return. The time passed quickly, and when my husband returned the three of us chatted about how well everything was going, what a good doctor I had, and what a wonderful thing it was to have a baby.

I was fortunate in having a pleasant resident physician on duty throughout my labor. He had a great capacity for enthusiasm and, on examining me, would say things like, "Well, would you believe five centimetres? That's terrific, five centimetres and you don't seem to be even feeling it! You're terrific, you really are! " This, of course, made me feel proud of myself, and my nurse reinforced this by repeating that it certainly was wonderful that things were going so well. I wonder if my lack of discomfort were not partially due to the way in which the resident and the nurse sustained my excitement and supported my most positive feelings.

By 11:00 p.m. I was in heavy labor. My nurse was going off duty and I was told I would soon be taken into the delivery room for the epidural. A new nurse came in then, asked a few questions and, on hearing that I had been there since morning, said something like, "Oh you poor dear. You must be exhausted." Her sympathy suddenly deflated me. I wanted people to be impressed with me, not sorry for me!

The nurse who took me to the delivery room was competent and pleasant enough, but did not seem at all interested in conversation. Later I heard her tell another nurse that she had not slept at all the night before and was simply dead tired. Again I felt a sudden letdown. I was only an ordinary patient, like all other patients, and the nurse was not eagerly awaiting the arrival of my baby; she was eagerly awaiting 7:00 a.m., when she could get some sleep.

Once the epidural was set up and my blood pressure and contractions timed, the nurse left me, saying that my husband would soon be with me. The delivery room seemed strange and both my husband and I missed having a cheerful nurse to talk to. Eventually, the resident, who had been having a short and well-earned nap, returned, examined me, and proclaimed that I was fully dilated. "Isn't that great? You'll have your baby very soon now! " Once again, with his enthusiasm, my spirits soared.

Time passed quickly until my doctor was called. By the time he arrived the room seemed to have filled with people. At 4:55 a.m., my daughter was born.

The whole experience of childbirth was an enjoyable and exciting one. I am grateful to the staff for the good care I received. However, I believe it might have been an even more wonderful experience if all of the nursing care had been of the same quality as that I received earlier in the day, so that my excitement and high spirits might have remained constant throughout. □

books

Leadership and the Nurse: An Introduction to the Principles of Management by Margaret Schurr. 116 pages. London, The English Universities Press Ltd., 1968.

Reviewed by Glennis Zilm, former assistant editor, The Canadian Nurse.

The dust jacket on this slim book says that it is intended for "first-line and middle-management nurses" and that it was published as a kind of response to the Salmon Report. This Report by the Committee on Senior Nursing Staff Structure, released in Britain about a year ago, strongly pointed out that nursing administrators needed management training.

The author, a one-time matron of a teaching hospital and now a nursing officer in the ministry of health, undertook to explore the necessary qualities of leadership and efficient management in relation to nursing.

"First-line and middle-management nurses" are, presumably, charge sisters (head nurses) and departmental sisters (supervisors). Miss Schurr suggests, however, that the principles will apply for the nurse-in-charge at any level.

Much of the material in this book is so basic that many of the principles could be found in high school self-improvement and personality texts on leadership. The book is part of the "Modern Nursing Series," written specifically for students in Britain's hospital schools. It is possible, therefore, that it might be useful for these students. In Canada and the United States, however, students would likely find the principles elementary and the terms confusing.

The book is divided into three sections: policy planning and organization; the art of communication; and meeting the needs of the individual. Of these, the section on communication is perhaps the clearest and would be the most useful to Canadian students. However, several other texts, such as Florence Lockerby's *Communication for Nurses*, offer more complete material on the subject. The Canadian Nurses' Association's *Manual for Head Nurses in Hospital* would be more useful on administrative principles.

Several times the author laments that nurses have never learned to perform management duties. For example, she says:

"On the whole, experienced nurses, however good they may be at their own work, are not so efficient when they have to perform duties such as dictation, which are commonplace in the life of most people in senior positions. This may be because in the past sufficient emphasis has not been laid on the need for nurses to be articulate. However, this should improve with modern nursing education, which encourages nurses to put thoughts and ideas forward for discussion."

Several places in the book readers will recognize and recall experiences of poor management techniques similar to those Miss Schurr describes. But this reviewer does not believe that this book will do much to improve nursing management.

Nursing Care Planning by Dolores E. Little and Doris L. Carnevali. 245 pages. Toronto, J.B. Lippincott Co. of Canada, 1969.

Reviewed by Dorothy Wasson, Director Nursing Education, Saint John General Hospital, Saint John, N.B.

This book presents a large topic – planning of patient care – in a well-organized, easy-to-read manner. The reader is introduced to some of the philosophies that underly patient care. In doing so, a number of questions are raised: What has the public come to expect as its right in health care? What beliefs do nurses themselves hold toward patients and toward nursing?

The processes involved in planning patient care are presented in some detail. Included are areas such as determining priorities in care, obtaining a nursing history, writing nursing care plans, and revising and modifying existing plans. A number of sample nursing care plans, which cover a wide range of problem situations, are presented.

The last five chapters are concerned with the introduction and implementation of a system of nursing care planning. Who is the logical person to introduce a new system? How best can staff be prepared to participate in planning patient care? How can the nursing care plan be used as a communication tool not only among nurses, but also among other members of the health team?

This is an enjoyable book to read as the authors have succeeded in conveying to the reader their interest in the topic discussed. The table of contents is fairly detailed, which is a help to persons looking for specific areas of information. A brief summary and a number of study questions are included at the end of most chapters. Not only are the study questions of value to the instructor, or to members of the inservice education department for student participation, but they also offer a number of thought-provoking ideas for the reader.

Because of the scope of the topic presented, many areas are not covered in depth in this book. This may limit its usefulness as a reference book in relation to a specific topic, i.e., use of the interview in obtaining nursing history. However, it should be a valuable aid to nursing instructors, supervisors, head nurses, team leaders, and others, both in clarifying their own thoughts on the value of systematic planning of patient care and in communicating this to other personnel.

A Psychiatric Glossary, American Psychiatric Association, 3rd ed. 102 pages. New York, Springer Publishing Co., Inc. 1969.

Reviewed by Micheline Montgomery, Nursing Service Instructor, Lakeshore Psychiatric Hospital, Toronto, Ont.

This small, soft covered book is the third edition of the *Psychiatric Glossary* presented by the American Psychiatric Association. Since its first edition in 1957, 300 more entries have been added, 150 of these since the 1964 edition.

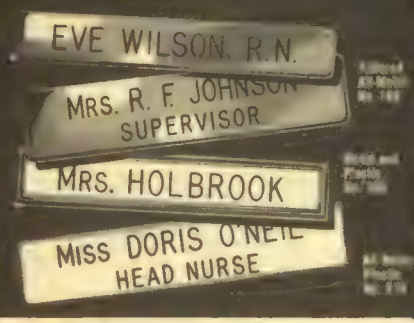
In this third edition terms on community psychiatry and the behavioral sciences are used, as well as terms on some of the latest forms of psychiatric treatment, e.g. aversive therapy and behavior therapy. Also, more terms on psycho-pharmacology, biochemistry, neurophysiology, and epidemiology have been added. Many other definitions have been reformulated to correspond with the 1968 revision of *Diagnostic and Statistical Manual of Mental Disorders*, also published by the American Psychiatric Association.

The explanation of each term is clear, concise, and written in language easy for a lay person to understand. Some words are italicized to make it more convenient for the reader to cross-check references.

This up-to-date, informative glossary would be useful as a quick reference for all concerned with the field of mental health. Its basic quality and simplicity would make it beneficial to schools and public libraries. It could also be of special value to nursing students and to all levels of nursing staff, especially those working in a psychiatric setting.

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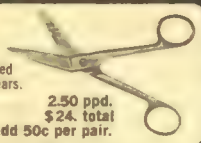
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books

Obesity And Its Management, by Denis Craddock. 200 pages. Toronto, Macmillan Company of Canada Ltd., 1969.

Reviewed by Virginia Rivard, Director of Nursing, Queen Mary Veteran's Hospital, Montreal, Quebec.

Obesity is rarely discussed as a separate condition, but usually is considered in association with other conditions. Here, however, the author has presented a universal exposé of this timely problem. The subject is treated in a logical sequence, beginning by outlining the problem and its complications. The causes are then analyzed from the physical and psychological viewpoints. The hereditary factor is given a strong note.

A section on treatment includes a descriptive section on diet, drugs, exercise, and moral support. Other areas are also explored: pregnancy, intractable obesity, diabetes, and childhood obesity. The final chapter, "The Future," is concise and to the point.

For the nurse and layman, the simplicity of style is excellent; the few more scientific sections can be skimmed without loss of the central idea. The pages on food values are especially interesting and complete: for example calories per ounce and units of carbohydrates per average serving are given for many foods. Emphasis is placed on the intake of sugar, which the author considers a more significant culprit than fats. The suggestions for diets are sensible without the rigidity which usually makes dieters feel guilty if they lapse.

The book is intended for physicians, although it could be helpful to anyone interested in weight control. The extensive references will be a great source of information to the physician.

Principles of Microbiology, 6th ed., by Alice Lorraine Smith. 699 pages. C.V. Mosby Company, Toronto, 1969.

Reviewed by M. Francis, Biological Sciences Instructor, School of Nursing, Regina Grey Nuns' Hospital, Regina.

This is an excellent text for the student nurse and the instructor. It is well illustrated, with subject headings and subheadings printed in red. The many tables, which are excellent summaries of important facts, are printed on pink to make them easier to locate. Most chapters conclude with questions for review, and a comprehensive reference section.

The author has divided the textbook into six units. Unit I, "The Introduction to Microbiology" contains the usual clas-

sification of microorganisms, but also includes a concise, up-to-date section on contributions to our knowledge of microbiology and a detailed discussion of the cell, "The Basic Unit."

Unit II discusses the bacterial cell, its biological needs and activities. Methods of studying bacteria by culture and direct examination are also outlined. The most useful chapter in this section is Chapter 10 on specimen collection. It includes precautions in collecting each type of organism and a table of important pathogens that could be found in each specimen.

Unit III is titled "Microbes' relation to infection and immunity." The normal body microbial flora is outlined as the course of infection and the body's defenses. It is in this unit that we find a chapter on allergies.

Unit IV, "Microbes destruction and inhibition of growth," includes not only a discussion on destruction by physical and chemical action, but a useful section on practical disinfection and sterilization.

Unit V is "Microbes, pathogens and parasites." As the name implies, this section discusses the pathogens and the conditions they cause. Included are the gram positive and gram negative organisms, the rickettsiae, the viruses, the fungi, animal parasites, and others.

Unit VI, "Microbes and the public welfare," includes a discourse on the usefulness of bacteria and the microbiology of water, milk, and food. The author has also included two chapters most useful to both the student and graduate in the community health program. These chapters include information on biological products from immunization and recommended immunizations.

The most outstanding and useful features of this book, both to the instructor and to the student, is the inclusion, at the end of each unit, of a laboratory survey pertaining to that unit and a unit test, using objective questions.

A Nurse's Guide to Anaesthetics Resuscitation and Intensive Care by Walter Norris and Donald Campbell. 164 pages. Edinburgh, E.& S. Livingstone Ltd., 1969. Distributed by Macmillan Co. of Canada Limited, Toronto.
Reviewed by Sister Camillus, Supervisor, Intensive Care Unit, St. Joseph's Hospital, London, Ontario.

This is an excellent reference book for nurses employed in the recovery room, intensive care and surgical units. The book's objective is to present the nurse's responsibilities in caring for patients before and after surgery.

Special emphasis is placed on the newer methods in anesthetics, analgesics, and resuscitation. In preparing the preanesthetic patient, the important steps are outlined, including the physical and psychological aspects. The complications of anesthesia in post recovery room care of patients are outlined in three main areas: gastrointestinal disturbances, respiratory difficulties, and circulatory changes.

Oxygen therapy and its toxic effects are dealt with effectively. One chapter presents in detail the physiology of patients with respiratory anomalies. Special procedures pertaining to a respiratory unit are well explained. The importance of highly skilled nurses to observe patients with respiratory problems and to administer intensive therapy is emphasized.

The appendix includes brief explanations on: anesthetic machines and electrical equipment; diets for uremic patients and patients on ventilators; instructions in physiotherapy and the necessity of physiotherapy in the immediate postoperative period to prevent pulmonary and vascular complications; care of the tracheotomy patient; precautions and recommendations to prevent fires and explosions in the operating room, and a detailed outline in the management of cardiac arrest.

The author has presented a concise, informative book on three extensive subjects.

Essentials of Nursing, 2nd ed. by Claire Brackman. 491 pages. Toronto, W.B. Saunders Company, 1969.
Reviewed by Miss Bugayong, Inservice Coordinator, Peel Memorial Hospital, Brampton, Ont.

Although this book is titled as a medical-surgical text, the book includes many subjects that will help the student comprehend her patient as an individual, as a member of his family and of society. The nursing care her patient needs for his illness, the rehabilitative measures, the preventive measures, and some of the health teachings in her capacity as a practical nurse are all treated as important aspects of nursing.

Personal hygiene, microbiology, mental hygiene, ethics, and anatomy and physiology all have been intelligently integrated. They are presented in such a way that the student appreciates and understands the meaning of her care to her patients.

The book is clear and easily understood, partly because of the author's awareness of the general need for knowledge of the practical nurse. While keeping the language simple, she has incorporated enough terminology to enlarge the students' general knowledge.

Illustrations and examples are frequent and to the point. Many of the examples are particularly pointed: the nurse who tells a patient he is about to have a "g.i.", and leaves him to puzzle and worry over what that is; and the nurse who is so accustomed to routine she gives the 80-year-old patient a daily bed bath, pathetically ignorant of the principles underlying her care.

The book's drawback lies in the fact that it does not emphasize team nursing. It also presents clinical case problems at the end of each chapter, when a nursing care plan could be more useful.

Textbook of Pediatric Nursing, 3rd. ed., by Dorothy R. Marlow. 687 pages. Toronto, W.B. Saunders Company. 1969.
Reviewed by Marilyn H. Clarke and Hazel Binch, pediatric nurses, Riverside Hospital of Ottawa, Ottawa, Ont.

This up-to-date, readable pediatric text places its main emphasis not on the diseases of children, but on their growth and development – physical, mental, and emotional – in health and in illness.

The introductory chapter gives an interesting concise history of child care through various ages, countries, and ethnic groups. It also gives a brief background history of some of the many laws and organizations that have been instituted for the protection and well-being of children.

Chapters two, three, and four deal with the general growth and development of children within the family, as influenced by heredity, parental attitudes, and illness. The nurse's changing role and her influence and importance to the ill child is well discussed.

The remainder of the book is divided into six units, each describing a specific age group and the diseases most prevalent to it. Growth and development and the reaction to illness and hospitalization specific to each age group is discussed meaningfully. Further information about the diseases, divided into short and long-term illnesses, could be obtained from the list of reference books and periodicals at the end of each chapter. This reference material is well-defined, and most of the material is available in nursing libraries.

Student nurses beginning pediatric study, or indeed anyone working with children for the first time, could use this book to gain valuable knowledge and understanding of the child as an individual in hospital and in the community. □

films

Don't Push Your Luck – 16 mm., 15 minutes, color and sound. Available without charge on loan from: The Canadian National Institute for the

Blind, 1929 Bayview Avenue, Toronto 350, Ontario.

The Canadian National Institute for the Blind released this dramatic film in March 1969. An industrial accident leads to blindness of a 50-year-old man. Throughout the film, the viewer sees the physical and psychological effects blindness has on the victim and his family.

Several valuable rules to safeguard eyesight at home and on the job conclude this thought-provoking film, which would appeal to a wide variety of audiences. □

accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, *except* reference items, which include theses and archive books that do *not* circulate, may be borrowed by CNA members, schools of nursing and other institutions.

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Stamps to cover payment of postage from library to borrower should be included when material is returned to CNA library.

Books and Documents

1. *Adolescence for adults.* Chicago, Ill., Blue Cross Association, c1969. 96p.

2. *Annual report of the Order of the Hospital of St. John of Jerusalem 1968.* Ottawa, 1969. 59p.

3. *An approach to the training of psychiatric nursing in diploma and associate degree programs; final report on the project* by Joan E. Walsh. New York, National League for Nursing, c1969. 113p.

4. *Biennial reports to the membership 1967/68.* New York, National League for Nursing, 1969. 45p.

5. *Canadian Hospital Association office and association directory, July 1969.* Toronto, 1969. 56p. R

6. *Collective bargaining in Ontario 1968* by Keith McLeod and Gerald Starr. Toronto, Dept. of Labour, 1969. 16p.

7. *Dermatologie* par Carmelle C. Plourde. Ottawa, Renouveau Pédagogique, c1968. 49p.

8. *Diamond jubilee conference of the New Zealand Registered Nurses' Association handbook, Wellington, April 15-17, 1969.* Wellington, Percival Publishing Co., 1969. 96p.

9. *Guide du journaliste.* Montréal, La Presse Canadienne, c1969. 127p.

10. *Histoire de l'obstétrique et de la gynécologie* par Martial Dumont et Pierre Morel. Lyon, Simep, c1968. 87p.

11. *L'hygiène alimentaire de l'enfant* by P. Mozzicanacci. 8e éd. Paris, François & Moret, c1969. 95p.

12. *A manual of style for authors, editors and copywriters.* 12th ed. rev. Chicago, University Press, c1969. 546p.

13. *Medical history of Malta* by Paul Cassar. London, Wellcome Historical Medical Library, 1964. 586p. R

14. *Neurophysiological and behavioural research in psychiatry; report of a WHO scientific group.* Geneva, World Health Organization, c1968. 33p.

15. *New Guinea nurse* by Elizabeth Burchill. Adelaide, Australia, Rigby, c1967. 151p.

16. *Obesity and its management* by Denis Craddock. Edinburgh, E. & S. Livingstone c1969. 191p.

17. *La parole et l'enfant sourd* par S. Borel-Maisonny et al. Lyon, Simep, c1967. 92p.

18. *The planning of change.* 2d ed. Edited by Warren G. Bennis, Kenneth D. Benne and Robert Chin. New York, Holt, Rinehart and Winston, c1969. 627p.

19. *Practical nursing workbook* by Claire P. Hoffman and Gladys B. Lipkin. Philadelphia,

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Lippincott, c1969. 310p.

✓20. *A psychiatric glossary. The meaning of terms frequently used in psychiatry.* 3d ed. Washington, American Psychiatric Association, c1969. 102p.

✓21. *Psychothérapies de l'enfant* par Didier-Jacques Duché. Paris, Editions Universitaires, c1967. 263p.

22. *Recherches en pédiatrie. Rapport d'un groupe scientifique de l'OMS. Genève, 28 nov. – 4 dec., 1967.* Genève, Organisation Mondiale de la Santé, c1968. 27p.

23. *Report of Expert Committee on the Health Problems of Adolescence, Geneva, 3 to 9 Nov. 1964.* Geneva, World Health Organization, 1965. 28p.

24. *Report of Expert Committee on the Midwife in Maternity Care, Geneva, 19 to 25 Oct. 1965.* Geneva, World Health Organization, 1966. 20p.

25. *Report of Expert Committee on Planning and Evaluation of Health Education Services, Geneva, 28 Nov. – 4 Dec. 1967.* Geneva, World Health Organization, 1969. 32p.

✓26. *Report of Victorian Order of Nurses for Canada 1968.* Ottawa, 1969. 81p.

27. *Santé et équilibre de l'enfant; guide des infirmières et puéricultrices, parents et éducateurs* par Florence G. Blake. Traduction de Janine Pazard. Paris, Le Centurion/Sciences Humaines, c1969. 245p.

28. *Santé mentale de l'enfant et de l'adolescent; éléments du cours de santé mentale de l'enfant organisé par le Centre international de l'enfance* par Claude Kohler, rédacteur. Lyon, SIMEP, 1966. 155p.

29. *Second report of the Expert Committee on Medical Rehabilitation, Geneva, 12-18 November 1968.* Geneva, World Health Organization, c1969. 23p.

30. *The second ten years of the World Health Organization, 1958-67.* Geneva, World Health Organization, 1968. 413p.

✓31. *A study of staffing patterns in psychiatric nursing* by Kathleen Bueker and Helen K. Sainato. Washington, Saint Elizabeth Hospital, 1968. 103p.

Pamphlets

32. *A dialysis symposium for nurses;* report of Symposium for Nurses Specializing in Artificial Kidney Therapy, Philadelphia, 1968. Washington, U.S. Health Services and Mental Health Administration, 1968. 37p.

33. *Prevention of childhood accidents in Sweden.* Stockholm, Swedish Institute and the Joint Committee for the Prevention of Childhood Accidents, 1968. 40p.

34. *Report of Clarke Institute of Psychiatry 1968.* Toronto. 19p.

35. *Selected list of books and journals for the small medical library* prepared by Alfred N. Brandon. 1969/1970 edition. Chicago, Medical Library Association, 1969. p.130-150.

Government Documents

Canada

36. Department of National Health and Welfare. Research and Statistics Directorate. *Inventory of welfare research.* 2d ed. Ottawa, 1969. 105p.

37. Department of National Revenue. *Taxation statistics, 1969.* Ottawa, Queen's Printer, 1969. 180p.

38. Ministère du travail. Direction de l'économique et des recherches. *Grèves et lock-out au Canada, 1967.* Ottawa, Imprimeur de la Reine, 1967. 81p.

39. Science Council. *Report, 1968/69.* Ottawa, Queen's Printer, 1968. 40p.

USA

✓40. Dept. of Health, Education and Welfare. Public Health Service. *Guidelines to radiological health.* Washington, U.S. Gov't Print. Off. 1968. 173p.

Studies Deposited In CNA Repository Collection

41. *A study to determine the opinions of administrators and directors of nursing on five selected recommendations concerning nursing education included in the CNA submission to the Royal Commission on Health Services; March 1962* by Frances M. Howard. Montreal, 1963. 45p. R

42. *Who does the nursing student in a baccalaureate degree program of nursing consider to be her significant nurse model and why did she make this choice* by Williamina A. Watson. Minneapolis, Minn., 1968. 85p. Thesis (M.Ed.),– Minnesota. R □

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B.C. R.N. FOR GENERAL DUTY in 32 bed General Hospital. RNABC 1969 salary rate $508—$633 and fringe benefits, modern, comfortable, nurses' residence in attractive community close to Vancouver, B.C. For application form write: Director of Nursing, Fraser Canyon Hospital, R.R. 2, Hope, B.C.

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December 1969

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The Canadian Nurse

A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 65, Number 12 December 1969

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letters

Letters to the editor are welcome.
Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Check your image

The Canadian Nurse is in the difficult position, by virtue of its "captive" audience, to chart a course that many of its readers would like to read. I don't know if an easy solution could ever be found for this problem: theoretically, this magazine stands as the body giving quasi-official thoughts on direction and purpose to Canadian nurses, and yet this kind of information is hardly what a captive audience would choose to read, one would think.

I believe that the October 1969 issue will polarize the opinions of many who read this journal. I am referring to the article "Check your image – it's slipping! " In it, the author attempts to equate professionalism among nurses with the tidy wearing of uniforms. In fact, she even seems to *define* professionalism by stating, "usually the professional shows his commitment to his calling by representing it well when on public view," following this with a series of examples and pictures of untidy nurses.

Nurses seem to have gotten themselves into a bind: so indoctrinated with the maxim that a professional appearance betokes a professional, they feel that by *looking* clean, crisp and competent, they are a credit to the profession. As a result of this, nursing service issues directives about skirt lengths and sweaters; in many places, a nurse with "time on her hands" is expected to clean cupboards, or perform other such tasks.

But perhaps this is no longer a significant issue. If nursing administrators choose to make it an issue, they are admitting, perhaps, that more relevant criteria for establishing professional behavior do not exist. It's easy to see if a nurse looks clean and to check off that category on her work-performance sheet, but it is significantly less easy to devise standards for professional behavior, and to figure out appropriate ways to measure if a given nurse has those qualities.

Better that we should stick to the image of the clean crisp nurse? Is it easier for *The Canadian Nurse* to meet the needs of those who would have issues stay the same, who would deny that issues of more vital importance for nurses do, in fact, exist?

I am not denying the importance of basic neatness. It is one means by which we pass information to others about our view of life and ourselves. One would suppose, though, that sloppy attire is one way for a nurse to express her dissatisfaction about her job, or with nursing in general. And it is the creative suggestions for minimizing the roots of discontent that should be given importance on your pages. As it stands now, *The Canadian Nurse* has lent an almost official support to Miss Zilm's completely *untested* statement that there is a correlation between professional behavior and appearance of the nurse in her uniform.

Is a doctor, in rumpled whites, any less professional? And would the pages of *his* professional journal tell him so? – Rosalind Paris, B.Sc.N., Montreal.

We received our October issue of *The Canadian Nurse* today, and the director of our school of nursing is so impressed with the article "Check your image–it's slipping! " that she has asked me to order two additional copies so that she can make a montage of the pictures to bring the message vividly to the nursing students.–Mrs. Elizabeth J. Guilfoil, Director of Medical Libraries, Sacred Heart Hospital, Spokane, Washington, U.S.A.

I thank Glennis Zilm for her article "Check your image – it's slipping! " (Oct. 1969). It certainly is time someone took this problem in hand.

As I am retired now, I wonder who is responsible for these particular matters. We do not have the old-time matrons now. There are so many directors, supervisors, and such that I am appalled when I meet nurses wearing uniforms around the streets and stores.

Again, thank you for the article. – Dorothy Sharp, Vanier City, Ontario.

I enjoyed the article "Check your image – it's slipping! " (Oct. 1969). The photographs alone told the story.

The thing that concerns me is that the nurse's image began slipping a long time ago, when waitresses, hairdressers, and domestic help donned white uniforms, nylons, and duty shoes.

Most persons cannot differentiate between these people and nurses. Therefore, I believe nurses are often unjustly blamed.

I am not saying that we are not at fault. We have all been guilty of one of these errors sometime during our career.

However, if persons in other careers would acquire some type of uniform that does not so closely resemble nurses' uniforms, we would look more closely and proudly at our own image. – Mrs. M. Cook, RN, Sarnia General Hospital, Sarnia, Ontario.

Miss Zilm wrote an interesting article in the October issue ("Check your image – it's slipping! "), and I had to agree with most of her points.

I say "most" because I noticed she said " . . . collective bargaining has raised salaries out of the poverty range." Too bad Miss Zilm did not inspect the salaries of Quebec nurses a little more closely. If my pantihose, which are quite expensive, have a run, or my uniform looks shrunken or gray, or my shoes have a hole in the arch, please don't criticize me until I can afford to buy new ones. My shoes, stockings, and uniforms may look worn, but at least they are clean. – Michelle Van Hinte, Montreal.

Defends telephone surveys

Editor's Note: In August 1968, an article on the self-defense of women, "Defend Yourself," by Loral Graham – then editorial assistant of The Canadian Nurse – appeared in the journal. This article was picked up by The Canadian Press and excerpts from it subsequently appeared in newspapers throughout Canada (as well as in The New York Times). The Winnipeg Tribune published this CP item this past October, and it was brought to the attention of ADCOM Research Limited, whose headquarters are in Toronto. The president of this company comments:

Your interesting article outlining precautions wise women take to protect themselves was sent to me by our field-interviewing supervisor in Winnipeg. I agree with the vast majority of the comments.

The statement that really stung me to the quick was this: "Reputable firms rarely conduct surveys over the telephone." This just is not true since we, and a good many other research companies, are both reputable and conduct many surveys over the telephone for some of the largest and most well regarded companies in Canada. We at least always identify both our company and the actual person conducting the interview, and this is the general practice.

Certainly, it is the privilege of any individual to refuse to be interviewed and this is accepted. It is also their privilege – though we hope it won't happen much – to call back and speak to our

supervisor who is on the spot. Incidentally, our interviewers are all women.

We are members of the Better Business Bureau of Toronto and in this area we have a bit of a problem in that there is at present no way of belonging to one Better Business Bureau and, by some sort of extra payment, also being registered with all the Bureaus.

Being interviewed on the telephone is safer than being interviewed at the door. How does one know that an unknown woman at the door is not a karate expert with an accomplice round the corner? At least no one can be rendered *hors de combat* by a telephone.

It may be of interest to your readers to understand what marketing research surveys are really about. They are, in one way or another, all aimed at finding out what our democratic society – and it is still basically a free enterprise society – is doing and thinking, wants to do and think. In this way, we are working to provide better ideas to make life a little more pleasant. Even if you do not particularly like television commercials, the eventual alternative is $100.00 a year or more each in taxes, and the option to see only whatever the government chooses to let you see.

I'm sure that there is one thing we can agree on. There are people who pretend to be conducting a survey, but who are, in fact, trying to sell something, often magazine subscriptions. We wish, as I imagine you do, that this could be stopped. – Adrian T. Gamble, president, ADCOM Research Limited, Toronto.

Timely and thought-provoking

I compliment you on the array of timely and thought-provoking articles in the October issue. "The Child with Leukemia" was so well presented, dwelling as it did on the mental approach to these children, the common-sense attitude toward specialized nursing care, and an optimistic atmosphere.

I chuckled over the delightful word picture of "The Coagulation of Harry," which intrigued and amused my teenagers.

I appreciated "The Nurse and the Sociopathic Personality," because I have never seen material dealing with this type of patient. This is a must for every nursing student, as contact with individuals like these can severely shake an inexperienced person's confidence.

An article like "Check your Image– It s Slipping" was long overdue.

My only criticism is the opinion page "Making a Comeback," by Mrs. B. Kowalchuk. This article does a disservice to the recruiting of older nurses back to the profession. If I had read it two years ago, it would have destroyed my desire to return to nursing and undermined my confidence.

I agree, however, with Mrs. Kowalchuk's suggestion of having part-time nurses during peak hours. This would eliminate much of the rushing about at bath-time, would give the nurse time to study her patient's condition and to give assurance when needed.

Yet, because nursing has always been a serving profession, it can never be subject to regular employment hours. Married women who have one paycheck should not expect the "plums" of a job when full-time staff must work shifts, weekends, and holidays.

There is a place in nursing for married women who have been inactive in their profession for some years. Most of us know how it feels to be a patient and suffer the physical indignities, the grating on edgy nerves, and the feeling that maybe something is wrong. Thus, when a patient complains that nothing is right, we keep trying until we convince her that we care what happens to her. How much satisfaction there is in hearing a fractious patient say with a smile, "That feels good, nurse! " – Mrs. Mary Grant, Islington, Ontario.

NLN note to nurse educators

You are undoubtedly aware that Canada will have its own nurse licensing examination service sometime in 1970, and the provinces will no longer be using the State Board Test Pool Examination from the United States.

The foregoing information seems to have been misinterpreted, so we are writing to assure Canadian nurse educators that the *selection* and *achievement* test services of the National League for Nursing will continue to be available to Canadian schools of nursing and boards of nursing as they have been in the past. We will be happy to supply more detailed information on request.–NLN Evaluation Service, 10 Columbus Circle, New York, N.Y. 10019, U.S.A.

Making a comeback

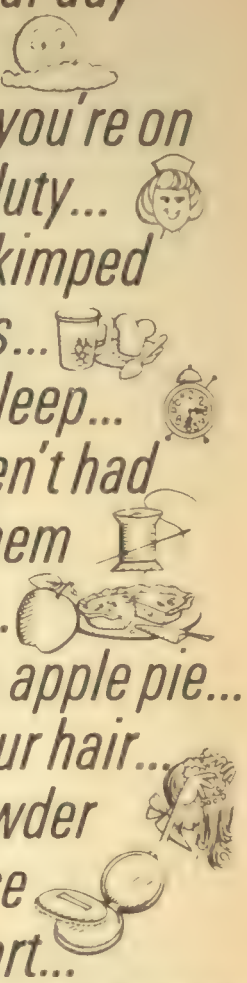
I read with interest the article "Making a Comeback" (October 1969) by B. Kowalchuk.

St. Peter's Infirmary in Hamilton, Ontario, has for many years hired part-time RNA staff to work the hours of peak activity in the morning. This suited the hospital and employee to such an extent that it was a surprise to find so little of it elsewhere.

However, my reason for writing is not to discuss hours, but to encourage Mrs. Kowalchuk as she searches for her "Utopia." It may take time before she finds what she wants, but nursing is too varied a field to admit defeat.

There are people in the community who need her valuable services. I suggest that she investigate the possibility of nursing outside the hospital setting. – C. Rorke, R.N., Industrial Nurse, Toronto.

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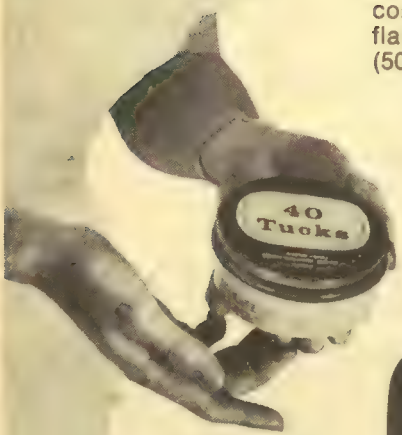
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letters

I hope this letter will be only one of many you receive in response to B. Kowalchuk's article, "Making a Comeback" (Oct. 1969). As I read it, her words echoed as if I had written my story. Her sentence, "I would like merely to keep my mind alert, and my nursing skills up-to-date, and be of some assistance to people" is the essence of how so many of us in our middle thirties feel.

This was what prompted me last year to call the hospitals in my area for part-time work. In those hospitals that did have part-time staff, their quota was filled and no increase was planned for the near future. Some hospitals did not wish part-time help because it was "hard on the bookkeeping."

I accepted a full-time job and was soon feeling fulfilled in my profession. But, as Mrs. Kowalchuk noted, the multitude of household duties and the care of a family soon began to require more effort for me to be efficient in both fields. It became necessary to make a decision – full-time nursing, or no nursing at all.

My family respected me as a working, contributing member of society; my teenage daughter seemed to respect my opinions more, and my husband was pleased with my happiness. Thus the decision to resign was a difficult one to make. I again hoped to find part-time employment, but this has proved unsuccessful.

Mrs. Kowalchuk's solution is an obvious one for the nurse: suitable hours for family routine and the feeling of being useful in giving the nursing care needed between 8:00 and 12:00 in the mornings and evenings. We are thwarted in this need by lack of foresight on the part of hospital organization.

It may be a cry in the wilderness, but such an idea may finally be heard before some of us are too old to contribute. – Joan Hodgson, Dartmouth, N.S.

It was with sympathetic interest that I read Mrs. Kowalchuk's article "Making a Comeback" (Oct. 1969).

I also took a refresher course as soon as my youngest child started school. Then I did some part-time nursing for three years. The hours I was needed most were during the evenings or nights and they certainly do not fit in with the needs of a growing family or a contented husband. Consequently, the hours that I do have free during the day are spent on volunteer work or hobbies that are not nearly as stimulating or as satisfying as nursing.

If there is this great need for nurses to come back to work, where can we fit in and still be good wives and moth-

ers? — Mrs. Shirley Tempest, New Westminster, British Columbia.

Final comment on February article

I am particularly glad of the opportunity to try to clear up some of the confusion caused by the article "Two-year versus three-year programs" (February 1969) in view of the letter from my colleagues at the Regina Grey Nuns' School of Nursing (September, 1969).

It seems to me that the letter from the Grey Nuns' School of Nursing is a face-saving one when such is not needed. For instance, addressing previous correspondents, they wrote: "Regarding the design of the study having limitations, we wondered why you did not mention the obvious point that the two groups of students followed a revised curriculum and that the conclusions might well have been different had the control group come from another school of nursing following a three-year, service-oriented program taught by different teachers."

I believe what they should have said is that the results would almost certainly have been different, but that any conclusions would have been well nigh impossible. This is so because the results would have been difficult to interpret when any differences between the experimental and control groups due to differences in length of course would have been confounded with differences due to the two nursing schools.

It was also noted in the Regina letter that in the original report "At no point was the statement of 'superiority' of one group over another made." It is true that the word "superiority" was not used, but to attack the critics on this ground is to confuse the issue. We certainly said, "This study provides conclusive evidence that the students in the three-year program performed better generally than students in the two-year program." We could very well have said that they were generally superior to the students in the two-year program.

There are many other confusions to be cleared up. I would quite happily address any gathering of nurses, if my basic expenses in attending such a meeting could be covered. In the meantime, I thank your readers for their interest. — C.G. Costello, Ph.D., Professor, Dept. of Psychology, University of Calgary, Calgary, Alberta.

This is the final correspondence that will be published about the article "Two-year versus three-year programs." — Editor.

Nurses respond

The advertisement for nursing personnel that we placed in your September issue has been a wonderful means of communication. We have received applications from 11 nurses and all referred to the ad in *The Canadian Nurse.* It also points out to interested nurses that the magazine is read and appreciated by nurses in general.—Sister B. Knopic, Director of Nursing, St. John's Hospital, Edson, Alberta.

Further response to minister's speech

I had two reactions to the speech given by the Minister of National Health and Welfare at the ICN Congress and published in the August issue of *The Canadian Nurse.* The opening paragraph put me off completely when I read the rather tired and overused introduction of "appropriate day to feel sick," and so on. As a result, my reaction to the first section was rather negative.

I wondered what kind of critical speech I was about to read wherein we were being warned about bankrupting the treasury and being told medicare would be for everyone if we — the professionals — would toe the line. But when I reached the end I felt there had been an impact, which, if nurses responded, could create a challenge and some action.

As the Minister developed his point, it became clear to me that he was criticizing the nursing profession as having developed two stereotyped groups of nurses: the hospital nurse and the public health nurse. Don't restrict yourself to these areas, he seemed to be saying. Get into areas where the need for nurses is great. Reduce the deadwood; get rid of monumental buildings; be realistic; use home settings.

These words struck home. I agree that the taxpayer will not be able to stand the escalating costs, and that the total health team must move into the community and reduce costs through preventive programs and the use of home settings.

Again, I agree with him that the nursing profession must be aggressive in regard to treatment programs. We verbalize about "getting back to the patient," but we sit in traditional settings and protect the old, acceptable ways, rather than trying to promote something new. If we are to play a role of greater importance in the health team, with more responsibility and independence, we will have to change.

I wonder what the reaction will be to his suggestion that nurses can take a great deal of the workload from the doctors? Do we believe this? Are we afraid of practicing nursing — or are we digging our heels in and saying "this is not nursing"?

I am pleased, too, to read that the Minister says that he does not pretend to know the best avenue for us to take and that he points to us to initiate reform and reorganization, not only in education, but also in patterns of practice. — Norah M. Stevens, Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia. □

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CNA Special Committee Report To Be Sent To Provinces For Further Study

Ottawa. – Restatement of the objectives of the Canadian Nurses' Association, clarification of the role of CNA, and a recommendation that the association be financed on a per capita fee basis are found in the report of the special ad hoc committee on functions, relationships, and fee structure. The report, presented to the CNA board of directors at its meeting November 7 by committee chairman Jeanie S. Tronningsdal, is based on the responses of questionnaires sent to the provincial nurses' associations, the CNA board of directors, and CNA professional staff.

The committee's recommendation concerning CNA objectives is essentially a change in wording, rather than in meaning. The recommendation that attempts to clarify the role of CNA says, in part, that the association should lead, coordinate and advise; that CNA is the voice for nursing on national and international levels; and that CNA acts as a catalyst for change by identifying trends and helping to implement new programs in the health, social, and welfare fields.

The committee report said that the majority of provincial nurses' associations favored a fixed per capita fee structure. This, along with the complexities of administering a sliding scale system for payment of CNA fees and the necessary curtailment of CNA activities that would result from a lowering of the average fee per member, convinced the committee that the per capita fee basis should be continued.

The report, which may still be revised in its organization and wording by the ad hoc committee, will be sent to the provincial nurses' associations for further study this month. The full report will be published in *The Canadian Nurse* in an early spring issue so it can be examined by CNA members prior to its presentation at the general meeting in Fredericton in June 1970. At that time, members will vote on the committee's recommendations.

The special ad hoc committee was set up at the association's 1968 biennial meeting in Saskatoon, on the direction of CNA membership, to investigate the question of fees and the roles and responsibilities of the national associations in relation to the provincial associations. The committee has held three meetings since it was organized.

CNA President And Committee Chairman Discuss Report



Sister Mary Felicitas, president of the Canadian Nurses' Association, with Jeanie S. Tronningsdal, chairman of the ad hoc committee on functions, relationships, and fee structure. Mrs. Tronningsdal presented the committee's report to the CNA board of directors in Ottawa November 7.

New CNA Bylaws Approved At Special Meeting

Ottawa. – At a special meeting of the Canadian Nurses' Association November 5, delegates from the 10 provincial nurses' associations voted in favor of adopting several new bylaws. The accepted bylaw changes for CNA were required to allow it to comply with the requirements of Letters Patent companies under Part II of the Canada Corporations Act.

Most bylaw changes were of a formal nature and were not commented on by delegates. A major change that disturbed delegates involved the required bylaw on withdrawal from membership in CNA. As presently worded and eventually accepted by the delegates, this bylaw states that any member may withdraw from the association by giving written notice. Several delegates expressed concern that this could lead to considerable confusion and weakening of CNA, as *individual* members could, by law, elect to withdraw from the national association.

Delegates from some provinces came to the special meeting prepared to vote on an amendment to the proposed bylaw on withdrawal. The delegates from the Association of Nurses of the Province of Quebec had a mandate from their members to vote only on the bylaws as drafted, not on any amendments. To avoid delay in the issuance of Letters Patent, the decision was made to vote on the bylaws as proposed.

The CNA's legal adviser, George Hynna, told the delegates that there was nothing to prevent them from amending this controversial bylaw or any other bylaw at the next CNA general meeting in June 1970. He pointed out, however, that as soon as CNA is issued Letters Patent under the Canada Corporations Act, changes in bylaw amendment must be approved by the federal government's minister of Consumer and Corporate Affairs – the department charged with administering the Corporations Act.

The CNA is presently incorporated under the Special Act of Parliament. After two years of unsuccessful attempts

to get amendments to its Charter passed by Parliament, the association's board of directors decided in March 1968 to apply for Letters Patent under the new Canada Corporations Act.

Under this Act, CNA will be required to have an annual, rather than biennial, general meeting.

Provisional Board To Be Set Up For CNA Testing Service

Ottawa. – An important step toward the operation of the CNA Testing Service, which will offer nurse registration examinations to the provinces by August 1970, was taken by the board of directors of the Canadian Nurses' Association at its meeting November 4-7.

The CNA board passed a motion to set up a provisional administrative board to inaugurate the national testing service. An ad hoc committee, which the CNA board agreed to establish immediately, will recommend to the executive by January 1970 the terms of reference and composition of the provisional board. This new board will be responsible for the testing service until a permanent board is named.

Although the testing service is being set up under the auspices of CNA, the CNA board agreed at an earlier meeting that the service should eventually be set up under an independent board.

At its November meeting, the CNA board of directors considered proposals submitted by the College of Nurses of Ontario and several provincial associations on the structure, composition, and frame of reference of the testing service board. These recommendations will be examined by the ad hoc committee and by the provisional board when it is set up.

Since the CNA board decision in 1967 to use the Registered Nurses' Association of Ontario examinations as a nucleus for a Canadian, objective-type, machine-scored testing service, CNA and RNAO negotiating committees have been working out the details of the transfer of the RNAO testing service to CNA. The negotiations have reached the final contract stage, and the official transfer will be on May 1, 1970.

The RNAO testing service has been supplying Ontario and New Brunswick with registration and licensing examinations. Because of the need for French-language examinations, Ontario, unlike the other provinces, has not used the National League for Nursing Test Pool examinations. The NLN test papers will not be available outside the United States after the summer of 1970.

Quebec has used the NLN papers for its English-language candidates and has developed its own French-language examinations. The Association of Nurses of the Province of Quebec has agreed to accept nationally-prepared examinations as long as the French-language papers are not translated from the English but are prepared by experts in the French language.

CNA Executive Director Honored



Helen K. Mussallem, executive director of the Canadian Nurses' Association, was one of 26 Canadians who received the Medal of Service of the Order of Canada October 28, 1969. The investiture took place at Government House, Ottawa. Instituted during Canada's Centennial Year, the Medal of Service is given in recognition of "excellence in all fields of endeavour in Canadian life, and is indicated by the initials SM following the name and takes precedence over degrees.

CNA Board Adopts Educational Committee Motions

Ottawa. – The board of directors of the Canadian Nurses' Association agreed to adopt as a policy the statement that all teachers in nursing education programs should have as a minimal qualification a bachelor's degree.

This statement was recommended to the board by CNA's standing committee on nursing education during the board meeting November 4 to 7, 1969 at CNA House. The policy statement also says that in bachelor's and master's programs the teacher's degree should be one level above that for which the nursing student is being prepared.

At present, according to statistics in CNA's *Countdown 1969*, less than 50 percent of the faculty in both diploma and baccalaureate degree nursing programs are so qualified.

During its last meeting October 15 and 17, 1969, the education committee identified as a priority for research the topic "how students learn to nurse." The CNA Board accepted the committee's recommendation that CNA stimulate, encourage, and become involved in projects in this area.

The board also passed the education committee's motion that it believes the learning needs of students can best be met if opportunity for student involvement in planning the educational program is provided.

Committee chairman is Kathleen Arpin. Members include: Nora Tennant; Elizabeth M. Moore; Kathleen G. DeMarsh; Alberta Crouse; Ruby Dewling; Sister Clare Marie; Isabel A. Brown; Stella Driscoll; Thérèse d'Aoust; Mirth A. Doyle; and Jean Byam.

CNF To Receive CNA Funds For Research In Nursing Service

Ottawa. – The Canadian Nurses' Foundation will receive direct financial support for nursing research from the Canadian Nurses' Association.

This decision was made by the CNA board of directors at its November 4-7 meeting, on a recommendation from the standing committee on nursing service. The board's motion calls for not less than $2,000 and not more than $5,000 to be contributed to CNF each year for the

next five years. The exact amount is to be considered in the preparation of the next CNA budget.

The committee believed that such CNA action might encourage further donations to CNF from individuals and organizations. In its report to the CNA board, the committee emphasized that there is an "urgent need for research in many areas of nursing practice."

The committee's report identified certain areas in nursing that are in need of study, and recommended that these areas be brought to the attention of nurses doing graduate study. These areas are:

- Evaluation of the quality of nursing care.
- Job satisfaction of nurse practitioners.
- Performance of registered nurses graduated from baccalaureate and diploma nursing programs, and performance of licensed practical nurses.
- How nurses can improve their image to the public, to other health professions, and to other nurses.
- Research in areas of nursing practice.
- Delivery of nursing care: 1. ritualism vs. judgement, and 2. system of administration of medications.
- Use of ward managers.
- Turnover rates of nursing personnel: 1. causes; 2. relationship to job satisfaction; and 3. relationship to the quality of nursing care.
- Role of the registered nurse in outpatient and emergency services.
- Staffing in the outpatient department and emergency services.
- Staffing patterns in operating rooms.

The nursing service committee, under the chairmanship of Margaret D. McLean, held its last meeting of the 1968-70 biennium October 15-17.

Guide On Nursing Service Standards To Be Published By CNA

Ottawa. – Final revision of the self-evaluation guide on standards for nursing service was approved for publication by the board of directors of the Canadian Nurses' Association at its meeting November 4 to 7, 1969.

The guide was drawn up by CNA's ad hoc committee on standards for nursing service for use as a tool to evaluate the quality of nursing service.

Prior to final revision, the guide was tested in 23 areas throughout Canada, representing all areas where nursing service is provided. These included nine hospitals, three extended care facilities, four public health nursing agencies, four branches of the Victorian Order of Nurses, and three occupational health settings.

Results of the testing indicated that the nursing service standards were generally applicable to all areas where nursing care is given.

The self-evaluation guide will be available on demand from CNA. After it has been in use for some time, further revisions will be made if necessary.

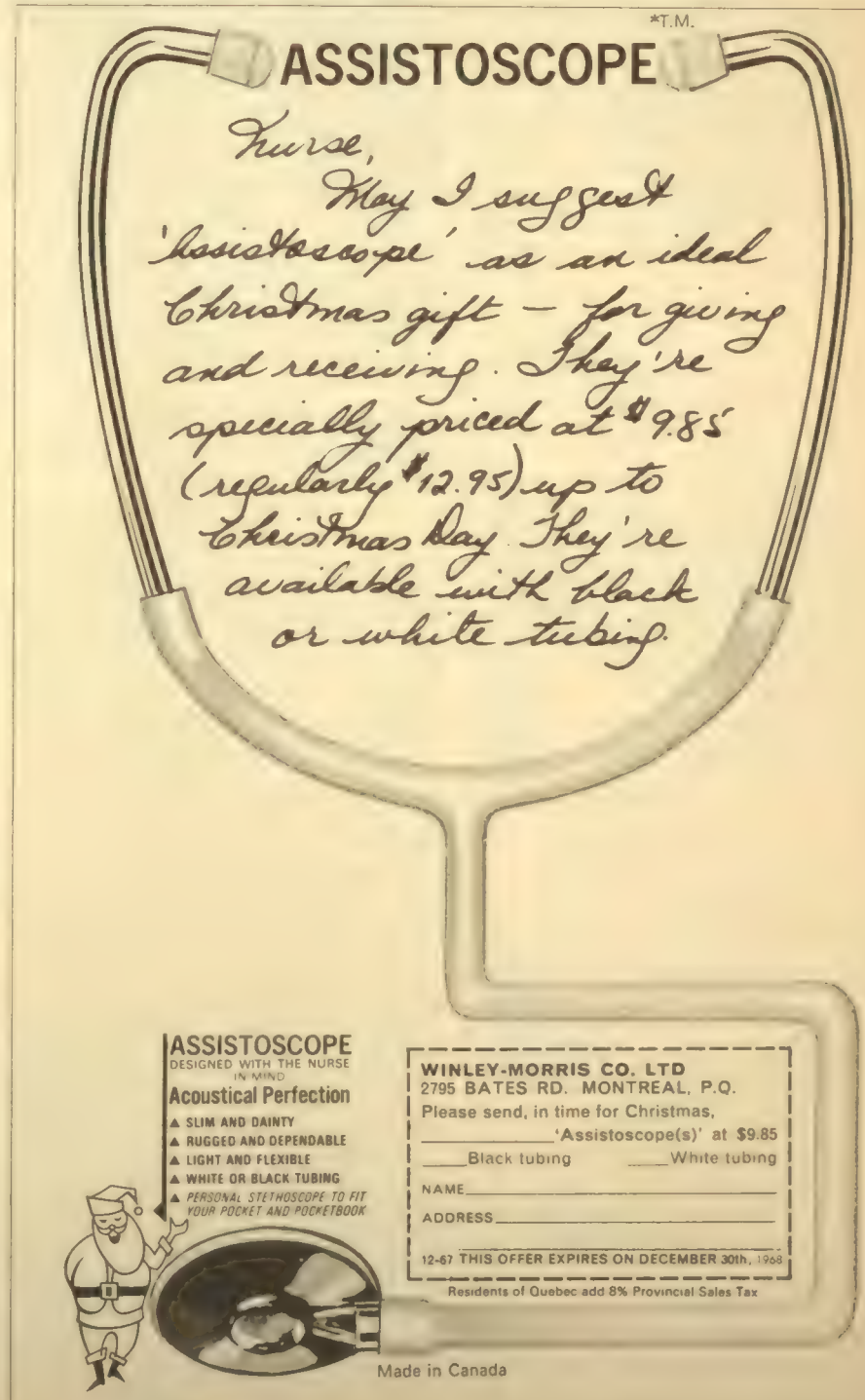
The ad hoc committee will now move into phase two of its activities, which entails developing standards for nursing care. The CNA board approved the committee's recommendation that it be restructured for this phase to include representation from education (in the university settting), from VON and public health, and from clinical practitioners in psychiatric nursing, medical-surgical nursing, and maternal and child health.

Some members of the present committee will be retained to maintain continuity. Present chairman is Irene Buchan.

Clinical Nursing Statement Revised By CNA Board

Ottawa. – Revision of the Canadian Nurses' Association's policy statement on the clinical nurse specialist was agreed to by the CNA board of directors during its meeting November 4 to 7, 1969.

Revision of the statement, which currently appears in CNA's *On Record 1968,* was recommended by CNA's com-



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- Nurse at the National Arts Centre
- Moditen Therapy in Psychiatry
- Sleep



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Dept. National Health & Welfare, Information Services, Ottawa, p.42

mittees on nursing education and nursing service at a joint meeting October 16, 1969.

The revised statement now reads:

"The clinical nursing specialist is an independent nurse practitioner prepared at the master's level with specialization and expertise in a particular area of clinical nursing.

"This individual should be responsible to the nursing director of the health agency and free of administrative duties. The clinical nursing specialist will enrich the quality of nursing care by demonstrating excellence in nursing practice, by utilizing available knowledge to effect improvement in care, by initiating and contributing to nursing research and by functioning as a resource person."

Chairman of the morning session of the joint committee meeting was Margaret D. McLean, chairman of the committee on nursing service; Kathleen Arpin, chairman of the nursing education committee, chaired the afternoon session.

CNA Executive Director Predicts Change In Science Of Nursing, Not In Art Of Nursing

Vancouver, B.C.—Educational systems of the future must make it easier for students to change the direction of their careers without unnecessary loss of time, Helen K. Mussallem, executive director of the Canadian Nurses' Association, told a large audience at the University of British Columbia October 24. "The ultimate choice of a career is usually the cumulative result of many decisions. The educational processes of the future must permit a student to upgrade his profession without starting at the bottom again," she said.

Presenting the Marion Woodward Lecture at UBC, Dr. Mussallem used the theme "Nursing Tomorrow" to range far over the field of health and related environments as it will exist 50 years from now. Predicting vast changes in medical knowledge, nursing science, nursing environment, and nursing practice, Dr. Mussallem also forecast an educational process that will be more flexible and permit easier upward mobility within the profession.

"In the next century," she said, "students bound for one of the health disciplines will first master a basic cluster of generalized knowledge and skills designed for health professionals. Specialization in any health field, including nursing, will take place at the postbasic level, and may involve a variety of educational approaches, including work-study programs and more intimate relationships between educational and service programs," she said.

Dr. Mussallem predicted vast change in the science of nursing but forecast little change in the essential art of nursing. "Human nature will not change," she said. "Man will respond then as now to the tender care and skilled competence of the professional nurse. The art of nursing will continue to be the application of scientific knowledge to increase human comfort and welfare."

Dr. Mussallem said that the rapidly accumulating knowledge in the health field will require a changing role for the nurse in relation to other members of the health team. "New skills, techniques, and methods will be interwoven to produce a new structure in terms of health care," she continued, "and in this new structure the nurse will become the primary contact professional. She will be responsible for the coordination of health services between the family, the hospital, and other health agencies. Nurses of the future will be more fully concerned with total individual health care.

"The nurse has a triple role in life," Dr. Mussallem said. "A nurse is part of the social structure, a member of the health team and, in the ultimate exercise of professional responsibilities, an individual alone with a patient. We cannot therefore look at the future of nursing as an isolated entity, but rather in the context of the delivery of health services to a community of people.

"The nurse in the next century will use the newest technological advances, such as the computer programmed by experts in the health field, to assist her with developing a total health care plan for patients in the community. Only when the nurse has doubts about the treatment prescribed or is confronted with a more complex medical situation will she consult one of the busy, highly specialized medical practitioners. He will probably be located in a modern health center and will employ both the nurse's description of the symptoms and the computerized medical record of the patient in making a medical decision.

"Having utilized modern technology and specialized medical knowledge, the nurse will then be in a position to use her nursing skills to prepare a total plan for the care of the patient, including the family's responsibilities."

A spectre that will haunt nursing for many years is that advanced technology in health centers will lead to a dehumanized atmosphere, Dr. Mussallem said. "Certainly no one predicts that there will be a 'warm computer' to provide emotional support to the frightened or confused patient. It is here, as all through the centuries past, that the nurse will maintain her unique and essential function of providing support, comfort, and highly skilled care to assist the ill to regain

health as quickly as possible."

CNA Biennial Convention To Open On A Sunday

Ottawa. – As a break with tradition the official opening of the 35th biennial convention of the Canadian Nurses' Association will take place on a Sunday. This decision was made by CNA's board of directors, meeting November 4-7, 1969.

The convention will be held June 14 to 19, 1970 in Fredericton, N.B., and is hosted by the New Brunswick Association of Registered Nurses.

Other board decisions on the convention are:

- Fees are to be $25.00 for registered nurses and $10.00 for students, with $7.00 for daily registration.
- Business sessions will be held Monday to Friday, with Wednesday left completely free and designated "Hospitality Day." NBARN will arrange special tours and entertainment for this day.
- Clinical interest sessions will be held during the week.
- The convention theme has not yet been chosen, but will center on nursing care. Provincial associations have been asked to send in suggestions.
- An interfaith service will precede the official opening.

Metric Conversion Kits Available From CHA

Ottawa. – In the September 1968 issue of *The Canadian Nurse,* an article "Plan your change to metric," contained information on Metric Conversion Kits for Hospitals.

At that time these kits were available from the Ontario Hospital Association at a cost of $1.00 for hospitals in Ontario and $2.00 for purchasers outside the province.

The Canadian Hospital Association is now responsible for distributing these kits. The CHA offers them to all hospitals in Canada for $1.00. Hospitals outside Canada can purchase a kit for $2.00.

For these kits, write to the CHA, 25 Imperial Street, Toronto 197, Ontario.

U of T School of Nursing Celebrates 50th Anniversary

Toronto, Ont.–The University of Toronto School of Nursing is presently marking its fiftieth anniversary.

Anniversary activities began with a conference sponsored by the faculty and the Alumni Association, held in the School in June. The conference was attended by nurses from many countries: Australia, India, Hong Kong, Malaysia, Turkey, Rhodesia, the United States, and all provinces of Canada. There was discussion of trends and developments in nursing education in Canada, and reports were given of research and special projects by Canadian nurses.

AARN Rejects Bill 119 Will Meet With Health Minister

Edmonton, Alta. – Alberta's Bill 119, designed to establish a provincial council of nursing, is unacceptable to registered nurses throughout the province as it now stands. This was the finding of a task committee set up by the Alberta Association of Registered Nurses to study submissions of its members on the bill, introduced during the last session of the Alberta legislature.

The committee recommended that new legislation should be introduced to ensure protection of nurses' professional prerogatives.

AARN representatives were to meet with Alberta Health Minister James D. Henderson in November to discuss the proposed new legislation.

AARN has approved in principle the establishment of a coordinated council of nursing, but believes the government's proposed council would have too much control over the nursing profession. The association believes coordination of nursing services through government legislation would be an important factor in improving patient care to the public.

PPA Answers Editorial On Postal Rates

Toronto, Ont. – The Periodical Press Association – an organization representing approximately 140 commercial and non-commercial publications in Canada – has expressed concern about an editorial in the June issue of *Canadian Hospital,* which referred to association publications supporting commercial publications through postal rates. ("News," *The Canadian Nurse,* Sept. 1969, p.16) According to a press release issued by PPA, the editorial is not factually correct, nor is it even fair comment.

"Neither Maclean-Hunter nor Southam Business Publications are being subsidized at the present rates they are paying for the mailing of their publications," the press release states. "By Post Office's own figures the new rates will more than cover the cost.

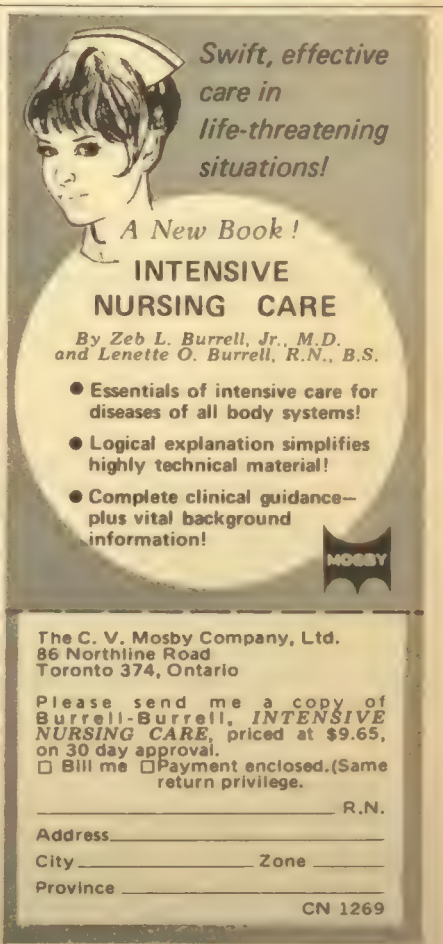
"We do agree that the discriminatory action of the Post Office to the association or non-profit publications is completely unjust," the press release continues. "Association publications may or may not be aware that as soon as we realized that these proposals were apt to become law, we alerted as many of the association papers as we could, including some of our own member publications. We urged them to make special representations to Ottawa. Most of them seemed to take the attitude 'It can't happen to us, therefore we will take no action.' In any event, little or no action was taken."

The press release continues: "When the Periodical Press Association did present a brief to Mr. Kierans, representatives of both Maclean-Hunter and Southam spoke on behalf of the association publications because the association publications did not feel they could make representations for a variety of reasons. We pointed out to Mr. Kierans the inequity of this particular clause dealing with the non-profit publications. Mr. Kierans did not seem concerned because he had heard no word from the association publications protesting this move."

In the press release PPA denies that its members lobbied for discrimination against the non-profit publications. "We have many valued association publications in our membership and we can assure you that this would not be permitted." PPA states that neither Maclean-Hunter nor Southam approached association publications in an effort to take over these magazines prior to the April 1st change.

"Write It Down" OHA Panel Suggests

Toronto, Ont. – "Write it down" was the unofficial theme of the nursing session on "The Nurse and the Law" at the Ontario Hospital Association's annual



convention in Toronto October 27-29.

Gordon Sullivan, a Hamilton lawyer, emphasized that a written policy adopted by individual hospitals and made available to nurses and medical staff would prevent many legal problems by making it clear to staff what procedures the nurse is legally able to perform. He also suggested that all verbal and telephone orders from doctors be written down by the doctor as soon as possible. "Don't just take a doctor's word," he warned, "because if a lawsuit is filed the doctor will be nowhere to be seen."

Mr. Sullivan reminded the nurses of the importance of keeping accurate charts for each patient. "These charts are admissible in court as evidence, he said. "They can also serve as a reminder to the staff involved if the case gets to court some time after the event being investigated."

Panelist J.W. Galloway, medical administrator of St. Joseph's Hospital in Hamilton, suggested that an up-to-date manual of hospital policy could be of considerable use to a nurse when she is uncertain of the legality of a procedure a doctor has asked her to perform. He also suggested that nurses who have proved themselves competent to perform certain medical procedures should be certified by the hospital, and their names kept on file, as several hospitals are now doing. "This would ease the problem of locating a doctor in case of emergency, or when doctors are not readily available, without putting the nurse in a legally difficult position."

All panelists reacted strongly to a question from the audience on the legality of the written order "Do not resuscitate" on patients' cards. "If you see it on mine, cross it out," said Mr. Sullivan, then told the audience that the law would be harsh if such a case ever came to court. Louise Hall, director of nursing at Peterborough Civic Hospital, commented that she had seen the notice "No code four" on patients' cards, indicating that they should not be resuscitated. "I've seen it on cards but it still shakes me," she said. "On checking, I always discover that the patient has little hope of recovery, and that by calling staff from other jobs in the hospital, the lives of other patients with a good chance of recovery could be endangered," she added.

Senior Civil Servant Misquoted In Newspaper

Ottawa. – Dr. W.S. Hacon, Director of Health Resources, Department of National Health and Welfare, was recently misquoted in an article in an Ottawa newspaper and presumably in other papers in the country. During the National Health Manpower Conference held in Ottawa Oct. 7-10, Dr. Hacon issued this statement.

"I would like to correct a statement appearing under a headline in the *Ottawa Citizen* on Wednesday, October 8th that I consider that nurses are over-educated. The direct contrary is true.

"The statement was out of context and due I believe to over-condensation of interview material during the editorial process. It was extracted from a broad review of differing opinions held across the country."

New Brunswick Nurses Sign New Contract

Fredericton, N.B. – The New Brunswick Hospital Association and the New Brunswick Association of Registered Nurses signed a collective agreement on behalf of its public hospital staff associations on August 29, 1969.

Fourteen hundred New Brunswick hospital nurses had threatened to leave their jobs in August because of a contract dispute. They withdrew their resignations in early August.

In an earlier statement to *The Canadian Nurse,* Marilyn Brewer, spokesman for the nurses' negotiating committee, said that early negotiations with the NBHA had been futile because of constant changes in management representatives and lack of preparation on the part of management between meetings.

In the new contract both parties agreed that a management labor relations committee should be maintained or established within 30 days of signing the contract. The committee consists of a specific number of members of the administrative staff of the hospital named by the administrator, and a specific number of members appointed by the staff association and unions representing other staff of the hospital.

A joint consultation committee, composed of the president and one other representative of the staff association, and the administrator and director of nursing or delegates will meet at least twice yearly.

Salary was a main point of negotiation between the NBHA and NBARN. No longer will New Brunswick registered nurses be the lowest paid in Canada. Under the terms of the new contract, they will receive $430 per month, retroactive to January 1, 1969.

Educational increments for registered nurses with additional preparation are also included in the agreement. A nurse with a master's degree in nursing will receive an additional $60. per month, and a nurse with a baccalaureate degree will receive an additional $50 per month. Educational increments will also be awarded to a registered nurse who has completed an accredited oneýear university course in nursing ($25. per month); a registered nurse with special clinical preparation of six months or more ($15. per month); and a registered nurse with the Canadian Hospital Association/Canadian Nurses' Association Nursing Unit Administration Course ($5. per month).

Nurses authorized to work overtime will be given the choice of payment at the regular rate or time off at a mutually acceptable time to the nurse and the hospital. If the nurse chooses time off, it must be within 30 days of the overtime worked; otherwise she will be paid at the regular rate. A nurse required to work on a holiday will be given time off or overtime pay at the regular rate.

Other terms of the agreement include: recognition by a hospital that the NBARN staff association in that hospital is the sole bargaining agent for graduate nurses, registered nurses, assistant head nurses, head nurses, supervisors, instructors, full-time health nurses, full-time clinical coordinators, and full-time inservice coordinators.

Regarding retirement benefits, a nurse retiring at normal retirement age who has served continuously for five years or more will receive a retirement allowance by the hospital. The allowance will be equivalent to five working days pay for each full year of service, but may not exceed 125 working days pay.

The contract also provides for 10 statutory holidays and all other days proclaimed as holidays by the Governor General and the Lieutenant Governor of the province.

All full-time nurses who have completed six months service are entitled to annual vacation with pay, calculated at the rate of 1 1/4 working days for each full calendar month of service, that is, 15 working days per year. After 10 years' service, a nurse is entitled to 20 working days vacation.

A dispute between a hospital and a staff association or a member of it on the interpretation, application, or violation of the agreement will be submitted to a grievance procedure, if it cannot be resolved by the two parties.

Nursing Administration Course Starts In Ontario

Toronto, Ont. – The first Canadian program for nursing home administrators was launched in October 1969 by the Associated Nursing Homes Incorporated Ontario.

The course uses a traveling faculty format that ANHIO believes is unique in North America. Sessions are now being held in Toronto, Belleville, and Ottawa, and further locations will be chosen.

The management development program for nursing home administrators was

established in recognition of the increasing need for formal preparation of nursing home administrators, according to ANHIO.

The program includes lectures, student presentations, case studies, group discussions, practical application sessions, and home study assignments. It is run by Personnel Systems Associates, a firm of management consultants retained by ANHIO as educational coordinators.

Candidates who successfully complete all the requirements of the program will be awarded a certificate by ANHIO.

NBARN Submits Brief On Maritime Union

Fredericton, N.B. – Mutual goals and responsibilities of the nurses' associations in the Maritime provinces as well as areas of concern specific to New Brunswick nurses were the subjects of a recent brief to the Maritime Union Study by the New Brunswick Association of Registered Nurses.

The submission followed an earlier meeting of representatives from the three Maritime nurses' associations.

"We believe that the services given by members of this Association to the people of New Brunswick constitute a public service," said the brief, "and that we have a responsibility to reassess that service within the scope of a Maritime Union Study."

The submission also pointed out that some 11 percent of NBARN's members have French as their first language. If Maritime Union were to become a reality, the French-speaking component would become a smaller minority within the overall Maritime total. Thus, special consideration would be needed to assure the French-speaking group of personal and professional rights.

The Maritime Union Study was authorized by the governments of New Brunswick, Nova Scotia, and Prince Edward Island to investigate and examine the possibility of increased governmental cooperation among the three provinces.

First Quebec Hospital Goes Metric

Montreal, P.Q. – St. Mary's Hospital in Montreal became the first hospital in Quebec to "go metric" in all areas of patient care, with its complete conversion October 6 to this scientific measurement system.

Executive director Sister Mary Melanie, who foresaw a trend to metric in Canadian hospitals, proposed conversion to this system two years ago.

"In this scientific era with men landing on the moon and other great technological achievements, it makes sense that we should speak in the language of science," Sister Melanie said. "There is a need for a universal system of weights and measures in the health sciences, especially in view of the increased tempo of the computerization of hospital data. Hospital application to the computer requires use of the metric system.

"Furthermore," she added, "if hospitals are to continue to make valuable contributions in the fields of medical research, education, and health care literature, they must be fluent in scientific speech."

Sister Melanie believes that most Canadian hospitals will convert to metric, wholly or partially, within the next few years. Several Quebec hospitals have already partially converted, but St. Mary's is the only large general hospital to convert everything and at one time.

NBARN Achieves Record High Membership

Fredericton, N.B. – For the first time, membership of the New Brunswick Association of Registered Nurses has exceeded 5,000.

The present membership of 5,095 includes 3,686 active members and 1,409 non-active members. Total membership this time last year was 4,783.

These figures represent a 3.8 percent increase in the number of active members, a 14.4 percent increase in non-active members, and a total increase of 6.5 percent over last year's figures.

Out of a total membership increase of 312, 135 or 43.3 percent are active memberships.

Nine male nurses are now registered with NBARN.

Conference Held For Dialysis Nurses

Hamilton, Ont. – The third annual conference for dialysis nurses was held in Fontbonne Hall at St. Joseph's Hospital September 27. The conference, chaired by Anne Donovan, coordinator of the dialysis center at St. Joseph's, was attended by dialysis nurses, technicians, doctors, and other interested personnel from Ontario and Quebec.

The morning session dealt with home dialysis, which is rapidly being developed in many areas in Canada. Dr. E.K.M. Smith described the home dialysis setup at Charing Cross Hospital, London, England, and Mrs. Lindsay Werden, a nurse on the staff of the St. Joseph's dialysis center, discussed nursing aspects. A movie was then shown depicting a day in the life of one of St. Joseph's home dialysis patients. Commentary was by Dr. G.D. Thompson and the patient concerned.

Mrs. M. Brock, director of the social service department at St. Joseph's, spoke on psycho-social aspects of dialysis. Her speech was followed by Dr. G.D. Thompson, who reviewed the hospital's three-

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year experience with chronic peritoneal dialysis. Dr. P.R. Knight concluded the session with a detailed review of the history and present status of kidney transplantation.

The fourth annual conference for dialysis nurses will be held again next year at St. Joseph's Hospital.

NB Nurses Discuss Trends In Diploma Programs

Fredericton, N.B. – Nursing education representatives from schools of nursing throughout New Brunswick met here in October to explore trends in nursing education at the diploma level and to clarify the role of the diploma program graduate in nursing service.

The two-day workshop was held at the headquarters of the New Brunswick Association of Registered Nurses. It was led by Anne Thorne, director of the new Saint John School of Nursing, which expects to receive its first students in the fall of 1970.

Among topics discussed at the workshop were: the product of the diploma program in nursing; approaches to curriculum development for diploma programs; potential curriculum courses; use of the laboratory for nursing; and evaluation of the student and the program.

Miss Thorne emphasized the importance of flexibility in curriculum planning, and noted that the inclusion of both general and specialized education was characteristic of newer programs in nursing. "The nursing school faculty has an obligation to keep in touch with changing needs for nursing services and for newer understandings related to teaching and learning," she said.

MARN Awards Bursaries

The Manitoba Association of Registered Nurses has awarded bursaries for 1969–1970 totaling $625.

Bursaries were awarded to Joan Mona Davidson to complete her master's degree at the University of Washington, and Leslie Anne Tatham, to complete her B.N. at the University of Minnesota.

A $500 bursary was awarded to Mrs. Ena Whalley to complete her B.N. at the University of Manitoba.

RN Internship Programs Starts At Chicago U

Chicago, U.S.A. – The University of Chicago Hospitals and Clinics have started a three-month internship program for registered nurses beginning employment at the university.

This program is to assist the new nurse to understand her role and responsibilities in the hospital environment, according to Lorraine Fernbach, RN, program coordinator.

"A relatively new idea, nurse internship has been established in several hospitals throughout the country because of the 'dynamics of science,'" said Mrs. Fernbach. "The increasing knowledge and rapid scientific changes now taking place have heightened the complexity of nursing duties and responsibilities to the extent that such programs are needed to give a practical orientation to what nursing is today."

During the first two weeks of the program, nurses are assigned to one of three teaching units: medicine, cardiovascular and thoracic, and medical cardiology.

The program will give nurses experience in such specialty areas as emergency rooms, coma unit, intensive care units, and the outpatient department at all hours of the day.

Special presentations, conferences, and demonstrations are planned, including a simulated cardiac arrest, a peritoneal dialysis, and tracheotomy suction.

ANA Releases Current RN Data

New York, N.Y. – A comprehensive survey on registered nurses has been published by the American Nurses' Association. The book, *RN's – 1966,* provides the most current detailed data on registered nurses in the United States.

This study is the fifth inventory of registered nurses compiled by the American Nurses Association. It shows that the number of RNs employed in nursing more than doubled from an estimated 299,000 to 613,000 between 1949 – the year of the first survey – and 1966. Although this number has grown steadily over the past few years, the increasing emphasis on health care in the US and advances in medical technology have made more acute the need for additional RNs.

RN's – 1966 includes national and state data on age and marital status, educational preparation, employment settings, and clinical practice areas of 909,131 registered nurses. Of this number, it was estimated that 295,943 nurses were not practicing in 1966.

This inventory was conducted under contract with the US Public Health Service, which provided financial support for data processing. The State Boards of Nursing assisted in collecting the data.

The book shows that 66.9 percent of the employed nurses worked in hospitals or related institutions. Private duty nurses constituted 9.9 percent, office nurses 8.2 percent, public health 4.5 percent, schools of nursing 3.6 percent, school nurses 3.5 percent, and industrial nurses 3.1 percent of the total employed.

The median age of employed nurses was 40.3 years. Sixty-four percent of the employed nurses were married, and 12 percent had been married.

The inventory also provides data on male nurses and inactive nurses. Noting recent efforts to attract more men into nursing, the study reveals that there were only 6,590 male nurses in 1966. The inactive nurses were predominantly young, married women, many of whom, the study suggests, return to nursing and represent a potential future supply.

Hospital To Keep Drug Databank

Montreal, Quebec. – Following successful testing at Man and His World over the past two seasons, Notre Dame Hospital has decided to maintain its databank of drug information, which is to be open eventually to doctors and druggists in remote locations.

The databank is the result of a pilot project carried out by Notre Dame at The Man The Explorer pavilion. Information stored in the hospital's computer includes drug type; when and how to use a drug; how the body uses it; how it is administered; its effects and possible counter-effects; its chemical structure and chemical name.

"We have tried to integrate drugs into a computer," said Dr. Jules Labarre, chairman of Notre Dame's medical data processing committee. "We aim at the safest possible drug treatment for hospitalized patients, and we think we have hit on a modern formula capable of giving concrete results."

Remote information on drugs can be obtained through an IBM typewriter terminal, which can be used to add to, delete from, or query the databank. A simple typed statement will generate the required information instantly.

Doctors at Notre Dame Hospital are now using a drug directory that tells them the drugs that should be prescribed. The catalogue has been prepared by the computer with the stored information. It can be updated as new drugs arrive on the market.

McGill University Project In Baffin Zone

Ottawa. – The Department of National Health and Welfare has entered into an agreement with McGill University whereby the university faculty of medicine will assist in a program of support to the health services of the Baffin Zone. The agreement was announced at a press conference in Ottawa in September by the Honourable John Munro, Minister of National Health and Welfare, and Dr. H. Rocke Robertson, principal and vice-

chancellor of McGill University.

The DNHW has assumed financial responsibility for the project, under which the university will provide needed medical personnel on a continuing basis to serve in the Baffin Zone, and will assist in the reception and discharge of patients in a major teaching hospital of the university's medical center.

The Baffin Zone of medical services comprises Baffin Island, the Melville Peninsula, and Southampton with a total population of about 6,000, of whom approximately 4,000 are Eskimos.

Mr. Munro said that this new development of health services in the Baffin Zone was based on two principles: "As far as possible," he said, "illness should be treated in or near the home of the patient. Both the adverse sociological consequences of evacuation to the south, and the cost, increase with the distance from home. These disadvantages can be overcome to a considerable extent by reinforcing the health team in the settlement and at Frobisher Bay Hospital.

"The final objective," he said, "will be to assist in the training of young Eskimos in the health services in hope that in the future they will themselves build a major role in the health services of the north."

The main base for the project will be Frobisher Bay, the largest settlement in the zone. At the present time, medical personnel for this area consist of the zone director, Dr. D. Horwood, and two doctors stationed at the Frobisher Bay Hospital. Each of the 12 settlements in the area has one or two nurses or a lay dispenser.

McGill will assist in the recruitment of general duty medical officers for the Frobisher Bay Hospital. In addition, two senior undergraduate medical students and two residents from McGill postgraduate training program will serve in continuity of short rotations at the base hospital in Frobisher or in the outpost stations.

Another feature of the agreement provides for visits of small teams of medical specialists as often as four times a year. Patients requiring this sort of attention will be treated in the zone rather than having to be evacuated to Montreal.

Dr. Douglas G. Cameron, professor of Medicine of McGill University and physician-in-chief at The Montreal General Hospital, has been appointed director of the project.

Family Physicians Meeting Sees Debut Of Convention T.V.

Toronto, Ont. – At the recent meeting of the College of Family Physicians of Canada held in Toronto September 29 to October 1, Hoffmann-La Roche Ltd., Montreal, presented for the first time medical convention television to some 800 delegates. Broadcasting was carried on throughout the three-day session and consisted of a variety of telecasts on medical and paramedical topics.

The important role of television in the continuing education of the family physician was reflected in the *raison d'etre* for the convention television: enlightening features for the physician to enjoy, run on a program schedule designed to complement the College's regular scientific sessions.

Operating Room Nurses Meet

Halifax, N.S. – Some 140 registered nurses from the four Eastern provinces attended the seventh annual conference of the Nova Scotia Operating Room Nurses Study Group held here in October.

A highlight of the two-day meeting was a panel discussion called: "Aspect Is Technique – Follow That Bug."

Other topics discussed included: operating room technicians and their place in an operating room; reconstruction surgery of the face; emergency care of patients with head injuries; recent developments in infertility; and renal transplants.

Donald Carruthers, operating room supervisor at the Victoria General Hospital, Halifax, opened the sessions. □



names

ANPQ Elects New Officers



Helen D. Taylor (center) was elected president of the Association of Nurses of the Province of Quebec at its annual meeting October 22-25. Miss Taylor, who succeeds Madeleine Jalbert, (right) as president, is director of nursing at the Jewish General Hospital in Montreal. Miss Jalbert, nursing consultant with the Quebec Hospital Insurance Service, remains on the ANPQ committee of management as first vice-president, French. Mrs. Ruth Atto, director of nursing education at Sherbrooke Hospital, was elected first vice-president, English. Second vice-president, French, is Rachel Bureau, (left) nurse educator with the Provincial Committee for the Prevention of Tuberculosis, Inc., Quebec City. Second vice-president, English, is Kathleen Rowat, assistant professor at the School for Graduate Nurses, McGill.

Because of several inaccuracies in the death notice of Mrs. Dorothy Warner (Names, October 1969), we are repeating the item — Editor.



Dorothy Isabel (MacRae) Warner, a well-known Canadian nurse, died in August of injuries received in a car accident.

Born in Stornoway, Quebec, Mrs. Warner received her basic nursing education at The Montreal General Hospital. After working as a staff nurse at MGH, she taught nursing at the Medicine Hat General Hospital for several years before returning to her home hospital as surgical supervisor of the outpatient department. Later, after some time spent as a night supervisor and floor supervisor at MGH, she became matron of Anson General Hospital, Iroquois Falls, Ontario.

In 1940, Mrs. Warner joined the RCAMC and went overseas as Matron of No. 1 General Hospital. In 1944 she was appointed matron-in-chief of the RCAMC Nursing Service in Canada, with headquarters in Ottawa.

After demobilization, Mrs. Warner took postgraduate study at the McGill School for Graduate Nurses and subsequently was appointed director of nursing at the Reddy Memorial Hospital. After this she nursed at various times in the General Hospitals of Montreal, Calgary, and Vancouver.

In 1958 Mrs. Warner was appointed chief nursing officer of the St. John Ambulance in Canada, a position she held until 1964. At that time she became head of volunteers at the Ottawa Civic Hospital.

Mrs. Warner's outstanding contribution to nursing will be well remembered by all those who worked with her in Canada and abroad. Because of Mrs. Warner's interest in and support of the Canadian Nurses' Foundation, a special memorial fund is being set up by her friends. Those interested in contributing to this fund are invited to send their cheque or money order to CNF, 50 The Driveway, Ottawa 4, Ontario.

Dr. John N. Crawford, deputy minister of National Health, retired in August. Dr. Crawford held this position in the Department of National Health and Welfare since 1965. Before this he was assistant deputy minister in the Department of Veterans Affairs.

Born in Winnipeg, Dr. Crawford was graduated from the University of Manitoba. He then joined the staff of The Children's Hospital of Winnipeg, the St. Boniface Hospital, and lectured in pediatrics at the University of Manitoba.

During World War II, Dr. Crawford was appointed Senior Medical Officer of the Canadian forces despatched to Hong Kong. Taken prisoner, he established a makeshift hospital in prison camp that provided the only treatment for allied prisoners until their release nearly four years later. For this he was made a Member of the Order of the British Empire.

After the war, Lt. Col. Crawford was director of medical research at army headquarters, later becoming deputy director general of medical services, and executive staff officer of the Canadian Forces Medical Council.



Madge McKillop (R.N., Moose Jaw General H.; B.N., McGill U.; Cert. in hospital organization and management, Canadian Hospital Association) has been elected president of the Saskatchewan Registered Nurses' Association. Miss McKillop, SRNA first vice-president for the past two years, succeeds Agnes Gunn of Saskatoon.

Miss McKillop is nursing administrator at University Hospital in Saskatoon. She previously held the positions of clinical instructor, associate director of nursing education, and director of nursing at the Royal Edward Chest Hospital in Montreal. During World War II, she served as a nursing sister in the Canadian Army in

(Continued on page 20)



Hup! Down! After 36 bends, man perspires. KLING* *Conform Bandage stays in place.*

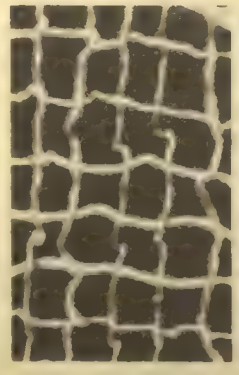
Gruelling knee-bend test shows why more hospitals use KLING Bandage every day

We put this man through the torture of 50 deep knee-bends to show you one thing. When you put a KLING bandage on, it stays in place. If you look carefully at the black stripe we painted on the bandage, you'll see the layers of bandage *haven't shifted at all.* KLING bandage held the primary dressing in one spot all the way through.

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KLING bandage conforms to the most difficult shapes. It stretches and recovers better than any non-elasticated bandage. And it clings to itself.

The reason lies in the way it is made. The threads are shrunk *differentially.* As they twist, they form little hook-like curls. These hooks hold successive layers together.



Little hooks in KLING *bandage prevent slip*



After 50 bends, black line shows no movement

Easy to apply

Because KLING bandage conforms so well, there's no need to tuck and fold when bandaging. Because it clings to itself, one can apply the bandage more quickly and easily.

You can bandage any part of the body with KLING bandage. A child's elbow—an athlete's knee. And you can be sure KLING Conform Bandage will stay in place.

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(Continued from page 18)

England, western Europe, and North Africa.

Miss McKillop has been active on nursing committees in Quebec and Saskatchewan. She has also been a member of the Canadian Nurses' Association's ad hoc committee to study functions and fee structure, and a member of the Saskatchewan Board of Nursing Education.

Eleanor R. Earle (R.N., A. Barton Hepburn Hosp., Ogdensburg, N.Y.; cert. in public health nursing, U. of Toronto; cert. in admin. and supervision, U. of Michigan) has retired as supervisor of public health nursing for the Leeds, Grenville and Lanark District Health Unit, Brockville, Ontario.

Miss Earle worked as a private duty nurse in Ogdensburg, N.Y. for three years after her graduation, then spent five years as a public health nurse in Woodstock, Ont. She then moved to Brockville as a school nurse. She has spent a total of 22 years as a public health nurse in the health unit.

The Manitoba Association of Registered Nurses has announced three appointments to its professional staff.



Bente Cunnings is interim executive director of MARN. A native of Denmark, Mrs. Cunnings (B.N., U. of Manitoba) taught public health nursing at St. Boniface General Hospital, Manitoba, and served as director of nursing service for the Sanitorium Board of Manitoba.



Laurel Rector is employment relations officer of MARN. Mrs. Rector (R.N., The Winnipeg General Hospital, B.N.Sc., Queen's U., Kingston, Ont.) has had experience in nursing in various fields, including general duty, public health, and supervision. She has also served as director and supervisor of nursing service at Pinawa Hospital, Pinawa, Manitoba.



Mr. T.M. Miller is public relations officer of MARN. A native of Scotland, Mr. Miller, has long been active in the community life of Winnipeg. He is a former president of the Manitoba division of the Canadian Cancer Society and a former president of the Manitoba Branch of the Canadian Public relations Society.

Pa Cartwright and Friend



Canadian-born actor Lorne Green, of "Bonanza" fame, and executive director of the Canadian Nurses' Asociation, Helen K. Mussallem, both received the Medal of Service of the Order of Canada at Government House in October. (See News, page 10).

At the inaugural meeting of the third Council of the College of Nurses of Ontario on September 19, **Elsbeth M. Geiger** was elected president. Miss Geiger is assistant administrator, nursing, at The Hospital for Sick Children in Toronto. She served on the previous Council from 1966 to 1969 and is a past president of the Registered Nurses' Association of Ontario.

Jean S. Dalziel, assistant professor of the school of nursing, University of Toronto, was elected vice-president of the Council.



Agnes Fleury (R.N., St. Boniface H.; B.Sc.N., L'Institut Marguerite d'Youville, U. of Montreal; cert. in Hospital Organization and Management, Canadian Hospital Association) has been appointed director of nursing service of the Manitoba Rehabilitation Hospital and the D.A. Stewart Centre in Winnipeg.

Miss Fleury, who joined the Sanatorium Board of Manitoba staff in July, has had extensive nursing experience. Most recently she was director of the school of nursing and assistant administrator of the Regina Grey Nuns' Hospital. Before this Miss Fleury was supervisor of the pediatric ward, night supervisor, and director of the school of nursing at the St. Boniface General Hospital, St. Boniface, Manitoba.

Miss Fleury has served as chairman of the nursing committee of the Catholic Hospital Conference of Manitoba, was a member of the Manitoba Minister of Health's Committee on the Supply of Nurses, president of the Catholic Hospital Conference of Saskatchewan, and a member of the executive committee of the Canadian Nurses' Association from 1964 to 1966.

Beatrice E. Stucker (R.N., The Montreal General Hosp.; B.N., McGill U.) recently was appointed nurse consultant, maternal and child health service, special health services branch for Ontario.

She began public health nursing with the Victorian Order of Nurses in Montreal, and has held positions as nurse-in-charge in the Arctic for the Department of National Health and Welfare, zone supervisor of nurses for Southern Alberta, and supervisor of VON in Scarborough, Ontario.



The new director of the Victoria Hospital school of nursing, London, Ontario, is **Beatrice Davis** (R.N., Children's Hosp., Winnipeg, Man.; B.Sc.N., U. of Western Ontario, London).

Miss Davis has held positions as teacher and supervisor at Children's Hospital, Winnipeg, and superintendent of general hospitals in Portage la Prairie, Manitoba, and Kenora, Ontario, and was director of the General Hospital, Parry Sound, Ont. She joined the Victoria Hospital's school of nursing in 1966.

Anne D. Thorne (R.N., Saint John General H.; diploma in teaching and supervision, McGill U.; B.N., McGill U.; M.Ed., Teachers College Columbia U., New York) has been appointed the first director of the new Saint John School of Nursing, Saint John, New Brunswick.

The first class of students will be admitted to the school's two-year program in the fall of 1970.

Miss Thorne was previously an instructor and associate educational director at the Saint John General Hospital School of Nursing. She has also worked as a head nurse in obstetrics at the Saint John General Hospital.

An active member of various committees, Miss Thorne has been on the Canadian Nurses Association's nursing education committee, and chairman of the nursing education committee of the New Brunswick Association of Registered Nurses. She is a member of the NBARN advisory committee on schools of nursing.

In 1968 Miss Thorne was awarded a CNF fellowship. □

dates

September 1969 — April 1970
Nine workshops, sponsored by the National League for Nursing, will be held across the U.S. They will explore new techniques and problem-solving approaches to hospital nursing, and will be conducted by nursing service administrative and supervisory personnel. For information and registration forms write: National League for Nursing, 10 Columbus Circle, New York, N.Y., 10019, U.S.A.

February 18-22, 1970
Conference on The Nurse's Reactions and Patient Care, sponsored by the Registered Nurses' Association of Ontario, Geneva Park, Lake Couchiching. Registration fee: RNAO members — $80; non-members — $95. This fee includes meals, double room accommodation, and general-conference expenses. For further information and application forms, write to: Professional Development Department, RNAO, 33 Price Street, Toronto 289, Ontario.

February 24-25, 1970
Institute on Nursing Home Care, Inn-on-the-Park, Toronto. Sponsored by the Registered Nurses' Association of Ontario, Associated Nursing Homes Inc., the Ontario Dental Association, and the Ontario Medical Association. For further information, write to the RNAO Professional Development Department, 33 Price Street, Toronto 289, Ont.

March 20, 1970
Seminar sponsored by The Operating Room Nurses of Greater Toronto, Royal York Hotel, Toronto. Direct inquiries to: Mrs. Jean Hooper, Chairman, Public Relations Committee, The Operating Room Nurses of Greater Toronto, 43 Beaverbrook Avenue, Islington, Ontario.

May 31-June 12, 1970
Ninth annual residential summer course on Alcohol and Problems of Addiction, Brock University, St. Catharines, Ontario. Co-sponsored by Brock University and the Addiction Research Foundation of Ontario. Enrollment is limited to 80. Basic information and findings of current research relating to the misuse of alcohol and other drugs will be presented. Provision will be made for discussion of prevention and treatment aspects of addiction problems. Address enquiries to: Summer Course Director, Education Division, Addiction Research Foundation, 344 Bloor Street West, Toronto 181, Ontario. ☐



HE NEVER TASTED MILK

SOCRATES CHAVEZ, SOUTH AMERICAN, AGE 4. Large family. Father dead. Mother works as laundress. Earns $20 a month. Struggles to feed family. No milk. No meat. Clothes given by charity. Live in smelly, dusty slum. No paving, street lights, sewage system or garbage disposal. "Home" is shack made of split bamboo mats. Dirt floor. No electricity. Use candles. No running water. No toilet. Socrates sleeps with three brothers in bed without mattress. Situation desperate. Help to Socrates means help to entire family.

Thousands of children as needy as Socrates anxiously await "adoption" by you or your group. Choose a boy or girl from South Korea, Viet Nam, Hong Kong, the Philippines, Bolivia, Brazil, Columbia, Ecuador or Peru. ☐ A monthly cash grant helps provide primary school education for your Foster Child and his sisters and brothers. In addition, PLAN gives family counselling, medical care when called for, supplementary new clothing and household equipment. ☐ PLAN's emphasis on education helps its children to become self-supporting citizens. Since 1937, more than 110,000 children have "graduated" from PLAN'S program. ☐ You receive a case history and photograph. Each month you write and receive a letter (original and translation). These letters will tell you how your "adoption" benefits the entire family. Soon, through the regular letters and PLAN progress reports, you and your child develop a warm, loving relationship. CHECK YOUR CHARITY! We eagerly offer our financial statement upon request. You will see that your contribution *truly benefits* the child for which it was intended.

PLAN is a non-political, non-profit, non-sectarian, government-approved, independent relief organization. Financial statements are filed with the Montreal Department of Social Welfare and other similar bodies.

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Scrub Station

This self-contained, stainless steel scrub station provides maximum convenience, comfort, and proper "no-touch," "no-splash" surgical scrub technique.

The sloping sink and knee operated water control and soap dispenser significantly reduce the cross-contamination hazard of the splash back and bacterial aerosol generated by the surgical scrub.

Water temperature and rate of flow are preset; there is nothing to adjust at any time. To start the water, a knee-controlled switch is pressed.

All units, whether single or multiple bay, require only one set of rough-in connections. The Market Forge Series SS-10 Scrub Station is available in Canada from Gordon G. Brown Co., Ltd., Suite 23, 1875 Leslie St., Don Mills, Ontario, or 25 Westminster Ave. S., Montreal 28, Quebec.



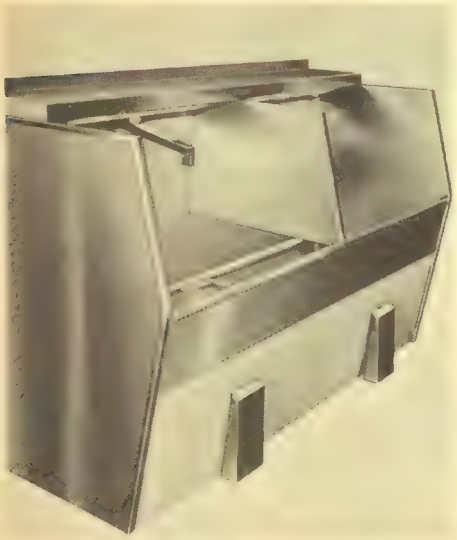
Irrigation Tray

The contents of this new irrigation tray are combined to offer greater convenience, more versatility, and better patient care.

The graduated 50 cc. syringe has a soft, pliant, "rubber-like" bulb designed to permit excellent fingertip control, provide greater protection, and allow more ease in use. The solution container, which has a 600 cc. capacity, is designed for tip-proof stability. The container may be used as a graduate for emptying bedside drainage units; the clearly marked graduations permit accurate monitoring of urinary output. The contour-shaped emesis basin fits snugly against the patient's body, and has an ample 1,800 cc. capacity in a spill-proof, easy-to-carry design.

All items needed for the irrigation procedure are included in the sterile, sequence-packed tray. The unit is compact, with contents enclosed within a CSR wrap. The irrigation tray is also available with 2 oz. piston syringe graduated to 50 cc.

For more information write to: C.R. Bard (Canada) Ltd., 22 Torlake Cres., Toronto 18, Ont.



Urinary Drainage Unit

This closed system permits irrigation or specimen collection without disconnecting the catheter by means of a plastic sleeve covering an entry port in the drainage tubing. This closed irrigation sleeve is a simple device that promotes better technique and can mean big savings in nursing time. The sleeve is slipped back, revealing the entry port. When irrigation or specimen collection is made, the sleeve is slid back into the closed position, resealing the system.

The large bore tubing promotes the free flow of urine into the drainage bag and virtually eliminates the possibility of a fluid column forming in the drainage tube. Elimination of this fluid column minimizes the danger of retrograde infection.

The exclusive ball check valve, housed in a rigid chamber inside the bag, separates the sides of the bag, permitting free entry of urine into the bag and eliminating the risk of blockage at the end of the tube. If the bag is tilted or dropped, the valve becomes a positive shut-off.

The shield at the end of the draw-off tube protects it from inadvertent contamination. The end of the draw-off tube should be attached to the stabilizer of the drainage bag, and the clamp left open. This procedure adds a unique safety factor: if the bag is not drained before it is completely filled, the over-flow will be automatically released out of the system, rather than back up or cause patient discomfort.

The drainage bag has an opaque white backing, which permits visual monitoring of the coloration and amount of urine flow. It is available as a kit, with all items needed for catheterization and closed system drainage, or as a single unit, with or without catheter.

This Macbick product is distributed in Canada through the Stevens Companies in Toronto, Calgary, Winnipeg, and Vancouver. In Montreal, Compagnie Medicale & Scientifique Ltée, and Quebec Surgical Company are the distributors. □



in a capsule

Nurses protest in 1918

What did nurses protest about in 1918? Considering that the first World War had just ended and nurses were settling down to a normal life, problems were not too great.

Yet, as shown from an editorial in the December 1918 issue of the *The Canadian Nurse,* nurses were quick to react when they thought their dignity was being compromised.

"When a recent book–*Canada in Khaki*–was published, the frontispiece, with an illustration showing one of 'our boys' with his arm around a nursing sister, was objected to by many nurses. The president (of the Canadian National Association of Trained Nurses, later the Canadian Nurses' Association) Miss Jean Gunn, wrote to the publishers, stating the view taken by the nurses that the illustration was, to say the least, undignified and did not in any way represent the wonderful spirit of service with which our nurses had met the difficulties of overseas work. The publishers were most pleased to change the offending illustration and were most courteous in their attention to Miss Gunn's request."

Surely publishers today would not commit such a *faux pas.* But, if after half a century they had not learned this lesson, would today's nurses be offended?

Bouquet to The Canadian Nurse

This was the title of a very complimentary item that appeared in the May 1969 issue of *The Nursing Director,* the newsletter of the Nursing Administration Section of the Ontario Hospital Association. After quoting excerpts from various items in *The Canadian Nurse,* the newsletter stated:

"In this and other newsletters we have referred to items which have originally appeared in "The Canadian Nurse," journal of the Canadian Nurses' Association. Quite apart from the fact that its pages have furnished us with material for comment, we feel it deserves our plaudits for another reason. It is quite evident that the editors have no hesitation in printing valid opinions even though they may be in direct conflict with CNA philosophy or stated policy. This is courageous journalism, something that other groups could well emulate. So to Dr. Mussallem and the editorial staff we say: "keep up the good work! We are certainly in favour of hearing all sides to the issues! "

And to the editor of *The Nursing Director* we say, "Many thanks for that most fragrant and welcome bouquet! It brightens our editorial offices considerably! "

A "Mess"

There have been various ways and means of measurement in use throughout history, but we came across an item which makes us particularly grateful for our array of measuring spoons, graduated cups and eyedroppers, and carefully weighed pills.

"Measurements for the early Canadian homemaker included such dosages as a 'cup' of catnip, elderblossom or peppermint leaf tea; a 'copious draft' of tonic brewed from green celandine; a 'little' pipissewa, green elder, and white henna; a 'bag' of tansy or asafetida; a 'pinch' of powder; a 'capful' of medicament; a 'few cloves' of garlic; and 'handful,' 'mouthful,' 'goodly portion,' 'generous helping,' 'batch,' 'mess,' and 'nip,'" says a release by the Council on Family Health in Canada, in a warning to mothers about administering medicine to their child.

It was the "mess" that stopped us cold.

More widows than widowers

How many women would be happy to know that they will continue to outlive men at an even greater rate than is now the case?

Now there are about 129 older women for every 100 older men. By the year 2000 the ratio may be 148 to 100.

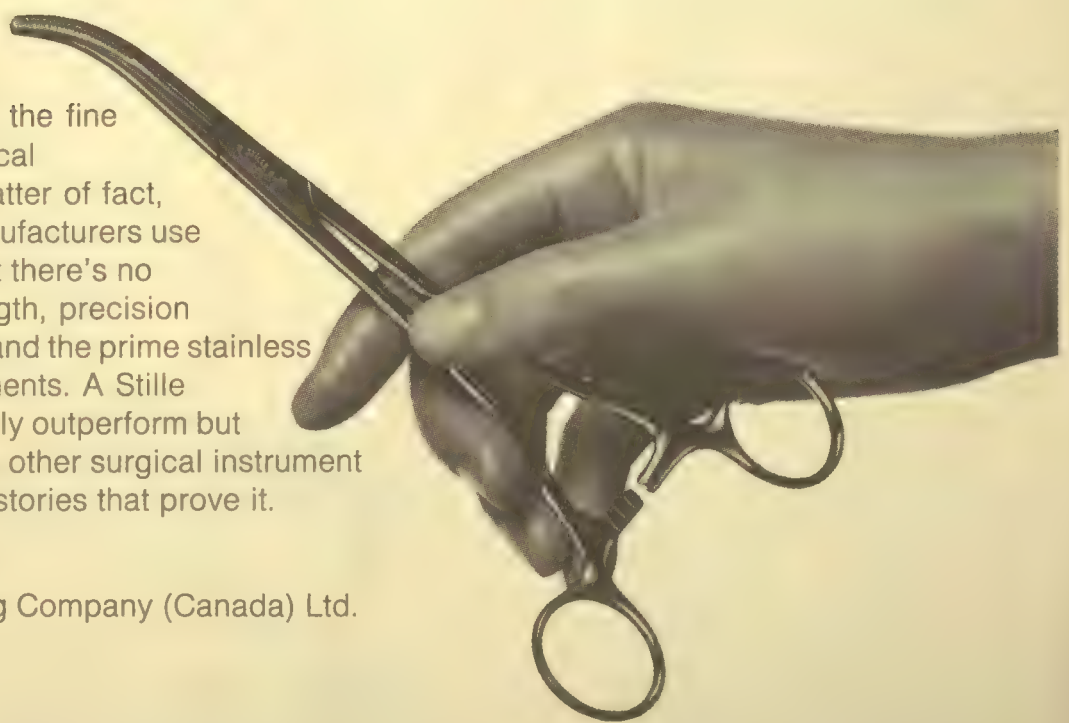
There are nearly four times as many widows as widowers. But there is at least one more encouraging fact: There are also 35,000 marriages a year in which one or both partners are over 65.

These statistics, reported in the *Globe and Mail* July 16, come from the United States, however. The article reports that doctors are interested in marital status of the aged because unmarried patients go to hospital more often and stay longer than those married. □



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Home for Christmas

A story of Christmas based on the experiences of Catherine W. Keith, who worked at the Fort George Nursing Station in Quebec in the early 1950s.

Harriet E. Ferrari

As the entourage approached the Fort George Nursing Station, the two nurses peering out the clinic window doubled up with laughter.

"I knew it! It's Emmaline! That's her brother Charlie beside the lead dog," Kay chuckled.

Hazel giggled. "She's done it again! I knew she'd be here for Christmas! "

Outside, Charlie, his dog team, and several relatives had grown from a speck on the northern Quebec horizon into a lumbering mass of fur parkas and wind pants at the station gate. With a final lunge they drew their burden to an abrupt halt in front of the steps.

From the komatik a ton of robes and skins were thrown off with a dramatic flourish – a flair perfected by repeated performances – and Emmaline emerged. She rose with an air of victory and

Mrs. Ferrari, a graduate of Moose Jaw General Hospital, is presently employed with Medical Services, Department of National Health and Welfare, Edmonton, Alberta.



home-coming, then put her mukluked feet gingerly into the snow.

"Queen of the North! " Kay grinned, as she went to the door to meet the Eskimos. "Wonder what her problem is this time."

In the small waiting room Emmaline solemnly shook the fur mitten of each escort before turning triumphantly to gain entrance to what she considered her personal haven.

"Her very sick, nurse," Charlie explained as his sister headed for the small two-bed ward that she had reluctantly vacated just three weeks before.

Having delivered their charge, the men turned and shuffled out. Weary from the long trek through the night, their sleepy eyes squinted at the sunlight shimmering across the snow-laden valley. Fort George, a cultural junction of what officials called "Indian, Eskimo and Others," was starting to show life. Charlie could imagine the heavily socked feet hitting the bare boards, the linoleum or a fancy rug depending on the status of the wearer. With a nod, he directed his companions toward a nearby oval-shaped canvas tent where cousin Josée would be brewing tea on the chubby wood-burning tin stove. With luck there might even be a pot of porridge thickening on the back burner.

Back in the station, Emmaline, with patronizing patience, allowed her hostesses to perform the various admission procedures necessary to gain inpatient status.

"Okay, you're officially in," Hazel said, wrapping the long maroon housecoat around the rotund guest, whose face broke into a beaming smile.

"Thank you," Emmaline acknowledged. She smoothed her still wet, newly disentangled, black hair. Then, smacking her government-slippered feet over the hardwood floor to the door, she swung into her role as station socialite.

Returning to the desk, Hazel watched the reunion. Head tossed back, Emmaline paused momentarily. Like a hunter leveling a harpoon, she thrilled at the prospect of the encounter; filled with self-assurance, she crossed the threshold of the second ward. Solemnly she gave one shake of the hand to both elderly Indian women, rubbed her stomach in a gesture of justified presence, and sank into the beckoning luxury of the well-cushioned maple wood armchair.

"She's home again," Hazel remarked wryly. "Wish *I* were."

Kay's glance swept the ward. There was Betsy, her skin like crinkled brown paper with the seasons of 70 years etched across her face, nodding and grunting her pleasure at Emmaline's return. Perched mid-bed, her wasting legs flopped under her ever-diminishing body, she brightened as a conversation took shape. The sparkle in her dimming eyes turned intently on Emmaline.

On the other bed sat Jane. Legs wrapped in a Hudson's Bay Company blanklet, she stared at her beloved moosehide moccasins resting on the chair. Despite intermittent kneading they still pinched her swollen feet. But they wery hers, one of the few prized possessions left, and she would not exchange them for a pair of department slippers offered by the nurses. At each offer, Jane's face, tightened already by time and the tendency to scowl, would harden and her braided head would violently shake her refusal to give up yet another custom.

Jane eyed Emmaline suspiciously. She had forgotten how Emmaline, by persistent coaxing and friendly bossing, had previously broken down her shell of bitterness and apathy, and had drawn her into cheerful helpfulness. The stacks of dressings, neatly cut and folded, were still not all used; the cotton balls, meticulously spun from long rolls of absorbent cotton, still filled several jars in the treatment room; the folded linen had been used and folded again, but had never been done with greater care. But that was last month and now Jane again drooped with lethargy and inner loneliness.

Busily engaged in the cleaning and wrapping of supplies, Kay and Hazel listened to the cheerful exchange between Emmaline and Betsy. Emmaline's choppy version of Cree dialect and Betsy's true Cree were bound together by freely disjointed English and seemed to mesh into a common tongue. Hoots of laughter and grunts of agreement filled the air. Jane hung her head, twisted her gnarled fingers, and stared at her mocassins.

Emmaline and Betsy were discussing the events of the previous evening, which had initiated the usual round of Christmas season festivities in the community. Last night, the school children had come to the nursing station for their annual "carol sing." Like a flock of geese they had fluttered in, excitement bubbling over their natural reserve, voices rising and falling in awe and anticipation at the sight of the tall pine hung with tingling, shimmering decorations.

Page by page they sang through the *Carols for Christmas* books. Squinting and bluffing, they got through the nonfamiliar verses, then burst into full voice at the choruses.

Nine- and six-year-olds, Brian and Stephen, sons of the Hudson's Bay manager; Mary, daughter of the Anglican missionary; and Charles and Harry, children of the school teacher, interrupted the sea of black hair with their bobbing blond and reddish heads. Kevin, a 10-year-old Métis who was unable to speak, contributed no sound, but smiled like an angel. Robbie, eight, who had a congenitally dislocated hip, leaned against the wall and rolled a beautiful soprano from his otherwise sturdy body.

Between carols there was shuffling and giggling, but each song was treated with the respect it deserved. Emmaline's young nephew, Billy, glowed with the rest, and the long hours of rehearsal suddenly seemed worthwhile.

When the last page was turned and after several rousing choruses of "Jingle Bells," Kay and Hazel plucked the lollipops from the tree and gave one to each child. Then the members of the chorus were invited to the nurses' living quarters — a not unexpected treat. The popcorn balls from the nurses' tree smud-

ged many a face but cleared the memory of many a needle. Before the kettle of hot chocolate was empty, many memories had been tucked away for reliving during the long lonely winter nights ahead.

On the way out, each child filed past old Jane and older Betsy, shook their frail, heavily-veined hands, and wished them "Merry Christmas."

Emmaline's nephew, Billy, had gone home all excited about the carol sing. Jarred by the reminder of the warmth, good food, and good compagny at the nursing station, Emmaline had taken a sudden "attack" early the next morning. She now munched away on a leftover popcorn ball, while her quick mind reviewed the possibilities of extending her stay at least until all the festivities were over.

Hazel gazed longingly at the picture on the wall of her native Nova Scotia and gave a long, hard sigh. "Do you think they will ever have a mail plane before Christmas at Fort George? " she asked.

"Don't know," Kay answered, "Hope so." Kay tucked the thermometer case and the stethoscope into the black field bag and snapped it shut. "See you at noon."

Home visiting this morning took on a new dimension for Kay. The "Hellos" were louder and warmer, the doors were opened wider in welcome, parents spoke with greater ease, and children smiled at everything and everyone. Each injection, each dressing, each word of health teaching, was received gratefully and each handshake projected a special "we're-all-in-it-together" message.

Kay's mukluks scrunched along in the frosty air as she made her way from house to house. The cold teased her cheeks and frosted her eyelashes, but one of her fur-lined mittens returned each wave as she plodded on. "See you tonight," she said gaily as she left each home.

Along the trails she hummed the age-old carols that would be sung again tonight. The non-native adults would do the honors, gathering in early evening and caroling to the local inhabitants, stopping at every door to visit briefly and shake the hands of the people inside. It would be an evening when goodwill and fellowship – taken for granted during the year – would be demonstrated. Kay hurried, thinking of the preparations yet to be made. The singing troupe would return to the nursing station after for hot punch and fruit cake in front of the fireplace.

Throughout the week there would be gatherings, the gaiety overlapping from one day to the next. That unique community spirit of small northern settlements would reach a new peak, to be climaxed on the morning of New Year's Day. That was the time the native people chose to make their official response to the offerings of friendship from the non-native populace.

At 8:00 a.m., the Indian and Eskimo men would group together to visit every non-native establishment. With guns on their shoulders they would stop at each door, and one man would mount the steps with a violin and play a favorite dance tune. When the music stopped, the others would shoot their guns into the air, a wild crescendo of greeting; sweets would be passed and hands shaken all around. At the last house, when the final shots echoed bluntly through the frost, the new year would be considered properly greeted and committed to *Peace on Earth, Goodwill to Men* – at least in Fort George.

Such is commuity nursing, Kay thought. It's not just the public health program and the care of patients. Community activities vary with the seasons, just as health problems vary, but over the year all these activities and the involvement of all the people add up to community well being. Every facet of community life – the mores that determine the work, the fun, the games, and the rituals – affects the health and happiness of its people. And we, the nurses, are a part of it. But only a part. We must lead and be led, teach and be taught, give and be given to, just like every other person here.

To be a part of it all – that was it, that's community nursing, Kay realized, her footsteps quickening. That's what this good feeling is. We shouldn't be homesick, even at Christmas. This is home – for now, this year, perhaps next year too.

Kay rushed up the nursing station steps and into the hall. "Hazel! " she called, looking around, "I'm home! "

Hazel looked up from the wild goose freshly unwrapped on the kitchen table. "Our Christmas dinner," she said, smiling. "Jane's sons, back from the bush for Christmas, brought it."

Kay turned her glance into the ward. Jane's squeaky laugh rose from the huddle around a small table in the middle of the ward. One hooked finger shook threateningly at her opponents. Emmaline gathered in the cards for the next deal and winked at Jane while Betsy glowed with shared satisfaction.

"Well, I never! " Kay exclaimed and went to the kitchen. She and Hazel nodded knowingly at each other.

"So you're home, eh, Kay? " Hazel teased. "Well, so am I, for now." □



Nurses and educational change

The author conducted a study to determine how effective Canadian nursing leaders have been in getting nurses' support for changes in nursing education.

Dorothy Kergin, R.N., Ph.D.

In a changing world, no occupation can consider itself to be a profession unless it continuously submits its practices and educational programs to self-scrutiny and self-evaluation, and modifies both when these analyses show that it no longer is serving the best interests of society. Among the professions, scrutiny and evaluation are generally done by those who serve as the profession's leaders.

To nursing's leaders belongs the responsibility for evaluating societal needs and estimating how nursing practice and nursing education should be modified to maximize the impact of the nurse on problems related to the effective delivery of health services. To these leaders also falls the task of enlisting the support of the rest of the profession to further necessary change. This paper considers how effective Canadian nursing leaders have been in obtaining the profession's support of educational change.

There is, first of all, a need to identify those who are the leaders of the nursing profession. In a cross-national study, Glaser identified the positions of those who served as nursing leaders.[1] His findings are as applicable to Canada as to other countries. He included the directors and faculty of educational programs preparing nurses; the interpreters of standards, the regulators of schools, and the gatekeepers for entry (that is, administrators of licencing agencies and consultants employed by governmental and professional organizations); the nursing executives of organizations employing nurses; and the elected officials and salaried secretaries of nursing associations. These are the nurses who serve as the profession's spokesmen in governmental, inter-professional, and public settings. One of the characteristics that is increasingly associated with the members of this group in Canada is the possession of a graduate degree.

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Study of professional attributes

An investigation completed by the author in 1968 provides a few insights into the effectiveness of channels of communication between those who serve as the profession's leaders and those who constitute a large proportion of the membership.[2] This study was concerned with professional attributes, including a few related to education and educational change. To carry it out, a random sample was drawn of female nurses, registered and employed in Ontario in 1967. In the sampling process, a different proportion was selected from each of three strata or groups, from among registered nurses with: 1. no academic degrees; 2. baccalaureate degrees; and 3. graduate degrees, that is masters or doctoral degrees.

Data were collected through a mailed questionnaire and questionnaire returns totaled 549, or 76 percent of the number mailed. For most of this discussion responses of nurses with graduate degrees and those with no academic preparation will be compared. These responses comprise, on the one hand, those of many professional leaders in Ontario and, on the other, responses of a representative proportion of rank-and-file members.

Findings indicate that of 65 respondents with graduate degrees, 86 percent

(56) occupied a position that corresponded to one of those identified by Glaser as "leader." Of the 180 without academic preparation, 66 percent (118) reported positions as staff nurses; 19 percent (35) stated they were head or assistant head nurses; and only 11 percent (25) held a position that fell into Glaser's category of leader.

As well as tending to differ according to position held, those with graduate degrees were more likely to be older, single, employed full time in nursing, and to be members of the Registered Nurses' Association of Ontario (RNAO) than were those with no university degree or certificate.*

One of the chief responsibilities of a professional association is to set rigorous standards for the profession and to help enforce them. For nursing, this includes the responsibility to promote standards of educational preparation that will foster the provision of a high quality of patient care.

For the Canadian profession, the spokesman on matters of professional concern is the Canadian Nurses' Association (CNA), in conjunction with its 10 provincial affiliates. Among policy statements issued by the CNA, several have been on nursing education. One such statement indicates that in future there should be two types of programs to prepare for nurse registration: the basic baccalaureate program and the diploma program, planned within the framework of two years.[3] A distinction in these statements is between the preparation of the professional nurse and that of the diploma nurse.

To assess how receptive or accepting registered nurses might be of CNA statements that propose change in basic nursing education, two items were included in the questionnaire relating to CNA's right to state two specific positions. The first item concerned the baccalaureate program as preparation for professional nursing practice, and the second, the two-year diploma program as preparation for technical nursing practice. For each item respondents were queried about CNA's right to take a stand and asked to indicate whether they would *agree with* or *oppose* the statements. Their responses, according to level of education, are shown in *Table I.*

TABLE I

Support of Opposition Expressed by Ontario R.N.s to Statements Regarding Professional and Technical Nursing Practice, According to Educational Preparation

Statements		Educational Preparation			
		No Academic Degree		Masters or Doctorate	
		No.	%	No.	%
1. Baccalaureate degree as preparation for professional practice.					
a. CNA's right:	support	74	41	53	83
	undecided	31	17	4	6
	opposed	75	42	7	11
b. Position itself:	agree	51	29	43	67
	undecided	32	18	9	14
	opposed	94	53	12	19
2. Two-year diploma as preparation for technical practice.					
a. CNA's right:	support	93	53	56	88
	undecided	29	16	2	2
	opposed	55	31	6	10
b. Position itself:	agree	70	41	47	74
	undecided	37	20	6	10
	opposed	66	39	10	16

Results

As shown in *Table I,* those without university degrees were less inclined to agree with both positions than were those with graduate degrees. The data indicate that, for the baccalaureate position, 29 percent of those without academic degrees expressed agreement, compared to 67 percent of the respondents with graduate degrees; and for the "technical" position, 41 percent of the former expressed agreement, compared to 74 percent of those with masters or doctoral preparation.

In both cases a larger percentage said they would support the CNA's right to express the position than would actually seem to support the position. It seems that a few hold to a philosophy of "I don't agree with what you say, but I'll defend your right to say it." For those who serve as spokesmen, this says that some members support the legitimacy of their leadership, without being in complete agreement with the stands they take.

But do Canadian nurses know what their professional association, the CNA, is saying on their behalf? Do those who serve as leaders know what those who comprise the rank-and-file believe? To assess this, items were included in the questionnaire to determine what the respondents knew about the CNA's policy statements on basic nursing education and what they themselves believed about future basic nursing educational programs.

In the case of the first of these items, the respondents were asked to indicate what they thought the CNA had stated about the types and numbers of future basic nursing educational programs; for the second, they were asked what they believed had been proposed concerning future basic diploma programs. Respondents who had academic degrees** and who were also members of the RNAO were most likely to know what the CNA had stated in both cases and to have supporting beliefs. For respondents without academic degrees, statistical analysis using the chi-square statistic, suggested that RNAO-CNA membership had little

*Membership in the Registered Nurses' Association of Ontario is voluntary.

**As well as 65 registered nurses with graduate degrees, there were 250 respondents with baccalaureate degrees included among those with academic degrees. The group without academic degrees was comprised of 45 nurses with a university certificate or some credits toward a bachelor's degree and 186 who reported no university courses.

effect on either knowledge or beliefs.

Members and non-members without academic degrees were equally ill-informed. Only about 20 percent knew that the CNA had issued statements indicating that in future there should be two types of programs preparing for registration as a nurse: the basic baccalaureate program and the diploma program, planned within the framework of two years. When asked what they thought about diploma programs in the future, approximately 50 percent of the 213 respondents without academic degrees expressed support for the two-plus-one program and over one-third thought that the CNA had proposed it.

Ineffective communication

This brief look at some aspects of intra-professional communication suggests that our channels are rather ineffective, especially the channels between the membership as a whole and those who speak for the professional associations. Certainly this seems to be true when one considers how well the membership is informed of proposals of the national association regarding future educational programs for nurses. Nor can those of us who call ourselves nursing educators consider that we have done a very thorough job of communication. This latter statement is supported by data pertaining to two other questionnaire items.

The respondents were asked whether they agreed, disagreed, or were undecided with respect to the following two statements:

1. Even with a sound theoretical background, the decreasing amount of practice in two-year diploma programs means that their graduates will be of very limited use at the bedside of patients when they first graduate.
2. Increasing emphasis on theory and decreasing amounts of practice in basic baccalaureate programs mean that future new graduates will be of little use at the bedside of patients.

These two are rather strong statements, since they both imply that new graduates of these programs will not be particularly useful in the area that nurses consider to be the primary place in which they carry out their nursing functions – the patient's bedside. The higher a nurse's educational level, the more likely she was to disagree with both statements. Of those who had no formal educational preparation beyond a basic diploma, three-quarters (121) *agreed* with the statement regarding the two-year diploma graduate, and two-thirds (114), with the one concerning the future graduate of a basic baccalaureate program. Even among those with masters or doctoral degrees, 18 percent (12) agreed with the first statement and 8 percent (5) agreed with the second. The sample of nurses without academic degrees represented a fairly substantial proporition of registered nurses employed in Ontario in 1967.

It seems that those who provide leadership for the profession have not yet achieved wide acceptance of the need for new concepts in nursing education to meet the new demands placed upon nursing practice. One wonders how the graduates of these two programs feel when they are placed in their first job situations following graduation, among work colleagues who consider them to be of limited usefulness.

We can only speculate whether these opinions about newly graduated nurses are part of an attitudinal set that forms the basis for a characteristic called by Reinkemeyer "anti-educationalism."[4] Or do these opinions represent a resistance to change, a resistance that is typical of professions and other occupations when behaviors, symbols, and norms begin to change and the means for attaining professional stature is revised. Like many groups, nurses are slow to accept change unless they are convinced that it is necessary. This suggests there is a need for a great deal of communication within the profession.

The whole matter of basic nursing education and the rationale for change need to receive full discussion at all levels within the nursing profession. In particular, this discussion must reach the local chapters, where the association's lifestream begins. One way in which this might be done is to establish special committees in the chapters, whose function would be to identify current issues within the profession, to explore fully and rationally the various positions that have been or might be taken with respect to these issues, and to lead discussions within the chapters. Such a committee ought to keep before it always the professional aim of public service.

Examination should be made of the health care needs of the Canadian people and of the educational preparation required to prepare practitioners who can handle effectively those functions that are within the prerogative of the nurse. It is of little use to propose educational change at the national level and attempt to legislate it at the provincial level, if the local environment forces graduates prepared in new programs to fit into old patterns, among work peers who question their capabilities.

It is time that we recognize that there *are* differences between the graduates of various nursing programs. It is time, too, for us to revise our expectations of their performance in work settings. The time is not far off when we must assign them different titles that reflect different performance expectations and educational backgrounds. Whether these titles are "professional nurse" and "technical nurse," or "clinical nurse" and "staff nurse," or something else, is not important. What is important is that we develop titles that are used consistently and which reflect agreed upon performance expectations.

A few years ago, Mallory succinctly identified the problem when she said:

"... difficult and perhaps costly, though its accomplishment may be, failure to achieve an understanding, articulate, and actively supportive membership may prove a serious stumbling block to the attainment of desired goals, particularly in the field of education."[5]

We do not seem to have eliminated this stumbling block. It is exciting and stimulating to contemplate the future of nursing education in this country and throughout the world, but let us make certain that this excitement is shared as widely as possible throughout the profession.

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Safe care for mother and baby

A British nurse looks at the pros and cons of home delivery in her country.

Kathleen Dicker, S.R.N., R.S.C.N., S.C.M.

Canadian nurses may be surprised to learn that in England some babies are still delivered in the home. To some this may seem a primitive, dangerous, and unhygienic practice, but in this article I hope to show that in England there is still a place for domiciliary confinement.

Forty years ago, most women here would not have thought of going to hospital to give birth, which was considered a simple domestic event. The fact that a small minority lost their lives was not questioned, for childbirth was known to have its hazards.

But our doctors did not share this attitude. Parturition, they reasoned, was a natural process, and with adequate care no mother or baby should be lost, whatever complications occurred during pregnancy and labor. Over the years they sent an increasing number of women to hospital, where all eventualities could be dealt with quickly and effectively.

Advantages at home

Why, then, do we still consider the home a suitable place for childbirth? One practical reason is that there are not enough maternity beds in hospitals to accommodate every expectant mother, and this will take some years to remedy. Another reason is that the geography of England makes it possible to have a safe domiciliary maternity service. Our towns and cities are never more than 15 miles apart, and the rural areas between are thickly populated, compared with a country such as Canada. Doctors and district midwives are always within a few minutes drive from their patients, and the services of specialized maternity units in the towns are easily available to them. It is possible to transfer patients to these units quickly at any stage of pregnancy or labor.

Each maternity unit also provides an obstetric emergency service, known as the Flying Squad, which goes out to treat mothers. When calls for help are sent via a reserved telephone line, two doctors go immediately by ambulance, bringing equipment for transfusion, a supply of Group O Rh negative blood, sterile packs of gloves, and portable anesthetic apparatus.

The most common emergencies are retained placenta and/or postpartum hemorrhage. After dealing with the situation, the doctors remain with the patient until her condition is satisfactory. Then they leave her in the care of her own doctor and midwife.

The Flying Squad also goes out to treat patients with serious antenatal emergencies. Severe antepartum hemorrhage and fulminating eclampsia are treated in the home, and the patients are transferred to hospital for intensive care. At present, an average of two Flying Squad calls per week occur in an area with a population of 125,000.

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No woman who is recognized during the antenatal period as being likely to develop complications is delivered in her own home. These complications include cardiac problems, women with Rhesus antibodies, and those who have had difficulties during previous labors.

Dangers of home delivery

When a research project into perinatal mortality was carried out 11 years ago, it revealed some dangers not fully realized before.* Statistics gathered then showed alarming mortality and morbidity figures for the second of twins and single babies born of multiparous women by the breech, especially when these patients were delivered in places where facilities for treating complications were not immediately at hand.

The study also showed that the dangers to both mother and baby increased considerably with the fourth and later children in a family. One reason for this was the unsuspected, unstable lie of the fetus, with its possible sequelae of malpresentation, obstructed labor, and prolapsed cord. Also, multiparous women are more likely to have uterine inertia during the third stage of labor, which can result in dangerous bleeding. All these factors

*The Perinatal Survey 1958 was organized by The National Birthday Trust, and its findings were published in 1963. All births that took place in the United Kingdom during the period from March 3 to 9 were studied. Detailed records were supplied by doctors and midwives. A further survey is planned for 1970.



Midwives in urban areas of England have walkie-talkies for calls.

can cause the death of either mother or baby, and sometimes both. Even if transfer to hospital can be made in time to prevent this disaster, the delay involved can result in brain damage to the infant.

The mother who had always had her babies quickly, with no problems, was thus recognized as one who possibly faced the greatest risk. Even though the risk of home delivery was remote, it was too great to take. It was often difficult, however, to convince these women that it was necessary for them to leave their families and go to hospital to be delivered. Now that we have a system that permits them to return home 24 to 48 hours after the baby's birth to be cared for by their district midwives, it is easier to gain their cooperation.

Home requirements

The number of domiciliary deliveries has declined over recent years and has been further decreased because of the housing shortage in England. The criteria for home delivery are a separate room where the woman can have her baby in absolute privacy, even if, the following night, her husband returns to share the double bed; an adequate water supply and sanitary arrangements; and domestic help from a relative or friend so that the new mother can rest for at least a week after the birth. Often the role of housekeeper is filled by the husband who takes his vacation at this time.

Early in the patient's pregnancy her doctor makes a careful medical, obstetric, and social assessment to decide whether she is more suitable for home or hospital confinement; usually he considers the patient's preference. If she is to have home delivery, her district midwife and doctor share her antenatal care. Naturally, she can be referred at any time to the specialized maternity unit if her progress deviates from normal.

The midwife inspects her patient's home to make sure it is suitable, and advises about preparations and the time to call her when labor starts. (Midwives in urban areas now have walkie-talkie radios for calls.) At delivery, the midwife supplies sterilized disposable equipment, analgesics, and oxytocic drugs.

Birth at home

The birth of a baby in the home is a truly happy occasion. Possibly because the mother is in a familiar place among people she knows, she often seems to have a more relaxed and rapid labor than her less fortunate sister who, for one reason or another, has to go to hospital.

Although Demerol is always offered in labor, the patient frequently refuses it and accepts inhalation analgesia – nitrous oxide with oxygen, or Trilene with air – for the delivery only.

The patient's doctor is informed when labor starts, and he is often present for the birth. But delivering the baby is considered to be the midwife's special privilege; if, as a courtesy, she asks the doctor if he wishes to do it, he usually declines, saying that she is the expert.

One great advantage of complete domiciliary care is that mother and child are safe from the possibility of cross infection. Delivery in the home is conducted with all the aseptic technique used in hospital. Patients assume either the dorsal or left lateral position as they prefer and their midwives find most convenient.

When working in the home, one must be adaptable. Beds are often so low that the midwife must kneel on the floor when delivering the baby. Surprisingly, perhaps, this kneeling position is quite comfortable.

It is common for the patient's husband to be present at the birth. As soon as this is safely accomplished, the grandmother and older children, if they are in the home, are invited to meet the new arrival. At this stage everyone takes time off to drink tea and eat cookies or cake, for labor can be hungry work for all concerned. While the mother sips her second cup, the midwife weighs and bathes the baby. She remains in the house for at least one hour, leaving when all the clearing up has been done, provided that her two patients are completely satisfactory.

The midwife visits twice daily for the first three days and then daily until the baby is 10 days old. The mother gradually assumes complete care of her child, and after the seventh day resumes her household work.

Comment

Some persons in England believe that a domiciliary maternity service, which includes deliveries, is too expensive in time and personnel. They advocate that all mothers be delivered in hospital, where a high concentration of skilled staff is already available. To ease the accommodation problem, these women could be sent home to the care of district midwives 24 to 48 hours after birth.

It seems unlikely, however, that a system that has been successful for so long and has become more efficient throughout the years will be abandoned. Those mothers who are able will continue to give birth to their children in the security and comfort of their own homes, with the advantage of the personal care of their own doctors and midwives. □

The nurse is a specialist in the artificial kidney unit

An introduction to dialysis nursing, with emphasis on the criteria needed for nurses who plan to work in an artificial kidney unit.

Christine Frye

A friend and I were enjoying a late lunch in the hospital coffee shop. Our conversation inevitably turned to dialysis, as he had spent many months as a patient on our chronic hemodialysis program before he had a successful kidney transplant. While reminiscing about his experiences on the unit, he gave me a valuable tip to pass on to our staff: "Don't ever say, in front of your patients, that you have just had a delicious ham sandwich! So often I would be staring at my lunch tray – which looked darned uninteresting because of my diet – and the nurses would start discussing the varied menu available in the cafeteria that day. It was terrible! "

My friend had a valid point. It seems such a little thing, but it was important to him. So often we forget that patients are people with feelings, frustrations, and unpleasant restrictions. This is true for all patients, but his comment was especially applicable to patients on the hemodialysis (artificial kidney) unit. On this unit the nurse has many added challenges and frustrations not encountered on general duty.

To the general staff nurse, hemodialysis is vague and unfamiliar. As the field expands, more and more skilled nurses will be required, and most of them will be transfers from other hospital departments. It is my purpose to present an introduction to dialysis nursing, with the emphasis on criteria for nurses.

What is dialysis?

Glomerular and tubular function in the normal kidney controls the excretion of metabolic waste products and excess fluid from the body. In renal failure, these products accumulate in the blood stream, resulting in the uremic syndrome with its many varied complications. The artificial kidney machine mimics the normal kidney, utilizing semipermeable membranes for dialysis and filtration.

In hemodialysis, the patient's blood is shunted from his body through a length of plastic tubing and membranes of cellophane or other material, and back to his body. Circulating around the membranes is a bath solution, "dialysate," containing the chemicals normally found in blood. Any substance – other than blood cells and most proteins – that has a higher concentration in the blood than in the bath will diffuse through the membrane into the bath and be discarded. Water will also be removed from the blood through hydrostatic and osmotic pressure.

Hemodialysis is used primarily for three different conditions. Most common of these is chronic renal failure, caused by kidney diseases, such as chronic glomerulonephritis and pyelonephritis, polycystic kidneys, and analgesic nephropathy. Dialysis is also frequently the treatment of choice in acute renal failure resulting from surgery, trauma, acute kidney infections, and other causes. Occasionally a patient may be dialyzed to remove toxins in cases of drug overdose or poisoning.

Many types of dialyzers have been used, but two basic kinds have become most popular. They require different techniques, but produce comparable results. The Ottawa Civic Hospital uses the twin-coil kidney, patterned after the design of Dr. W.J. Kolff, and modified by Travenol (Baxter Laboratories) and Kingmed Limited.

The actual work

Let us consider a typical dialysis in our unit for a patient with chronic renal failure. He is admitted, weighed, gets into bed, and has his blood pressure recorded. Dialysis is started, and he settles down to read, sleep, or watch television. He is questioned informally about his condition: how has he felt since his last dialysis? Does he have any new complaints? Are there problems with drugs or diet?

The patient's blood pressure is recorded every 20 minutes, or more frequently if it is above or below his normal reading. He may require mild analgesics for a headache or muscle cramps. He is served his meal according to the diet he is following. Blood is transfused through the machine if his hematocrit is below 15 to 20 percent. An antihistamine may be given before the transfusion, particularly

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A former patient and his wife (left) talk to the head nurse of the dialysis unit, Chris Frye, in the hospital coffee shop. This patient had a kidney transplant in 1968 and returns to the outpatient clinic every four to six weeks for a check-up.

if he has had previous blood reactions. A high machine pressure may be used to remove excess fluid from the patient's system, or fluid may be given through the machine to replace a loss. This need is determined by his pre-dialysis weight and the blood pressure readings.

If he is tense or anxious, he may be given a tranquilizer, either as a routine daily dose, or just as needed during dialysis. We have written orders for these routine drugs and treatments, so it is unnecessary to call a doctor for each little problem. However, a resident and staff physician are on call at all times when dialysis is in progress.

The dialysis runs for four to six hours, after which the patient is allowed to get up. If he feels well, he is weighed and goes home. If he prefers to rest, or does not feel well, his discharge is delayed accordingly. Most patients are dialyzed twice a week, during the day or the evening, depending on their working hours.

Criteria for dialysis nursing

What qualities, attitudes, or interests should the dialysis nurse possess? These can be summarized briefly: a willingness to specialize; an interest in chronic care nursing; ability to care for acutely ill patients; alertness; ability to work as a member of a small team; a positive attitude; and good health.

Willingness to learn a highly specialized type of work. Most nurses tend to forget all but the basics of anatomy and physiology after they finish training. The dialysis nurse must relearn this along with kidney function in health and disease. In addition, she must be aware of body chemistry, fluid and electrolyte balance, cardiorespiratory function, blood pressure control, nutrition, and so on. She must understand the principles and functions of the kidney machines, the cardiac monitor, and associated equipment and be completely capable of running them. It is to her advantage to spend her free time reading, studying, and asking questions.

Interest in caring for the long-term, chronically-ill patient. Chronically diseased kidneys do not recover. The only real hope of a chronic dialysis patient is to have a successful kidney transplant. While waiting for a suitable donor kidney, or if he is not a transplant candidate, his week-to-week existence depends on adequate dialysis. He is usually acutely aware of the severity of his illness and requires constant psychological support and encouragement.

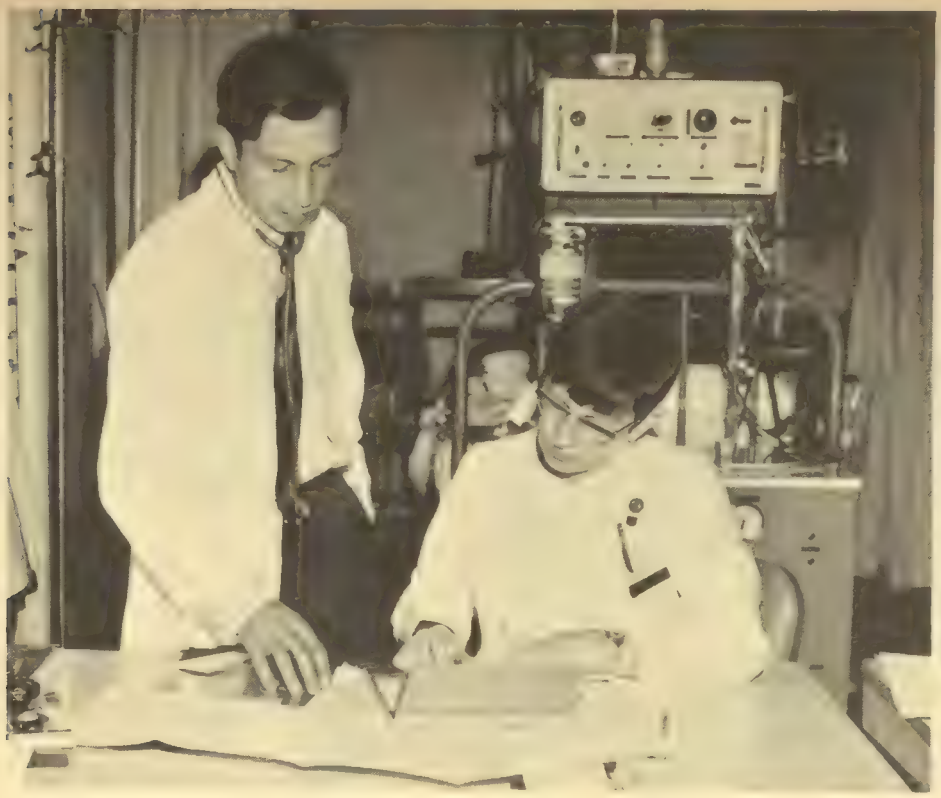
The dialysis nurse must be prepared to listen to the patient's problems and to decide when they should be brought to the doctor's attention. And she must watch closely for changes in a patient's condition, which he may be afraid to mention, or which he may not notice himself. The chronic dialysis patient requires little actual nursing care and should be encouraged to help himself as much as possible, but this is never an excuse for the nurse to refuse to help.

Ability to care for acutely ill patients during a complex procedure. Whereas chronic patients require little nursing care, those with acute renal failure are seriously ill. Intensive nursing care is required and is complicated by the dialysis procedure. Many types of equipment may be in use and the nurse must understand these. At the same time she must be aware of the hemodynamic changes that dialysis may cause, including wide fluctuations in blood pressure, the chance of clotting or hemorrhage, and the danger of dehydrating the patient or of over-loading the circulatory system, causing pulmonary edema and congestive failure.

If the patient is unconscious at the start of dialysis, he may gradually become more alert as his biochemical status improves. Thus a quiet, comatose patient may become a restless and frightened one over a period of a few hours. Constant observation is mandatory.

Alertness in the midst of routine. The chronic dialysis program consists of many routine procedures. When the nurse becomes familiar with them, she can relax and be comfortable with her work. Weeks may pass with little change in procedure and with little to challenge the nursing staff. However, they must at all times be alert and aware of what is happening in the unit. Mechanical failure of equipment, an unexpected power failure, or a sudden change in a patient's condition must be noticed and treated without hesitation.

One of the most common problems associated with the equipment is a leak in the dialysis membrane, allowing blood to escape into the bath fluid. If not detected immediately, this can result in a considerable blood loss from the patient. Many of the newer models of artificial kidneys



Dr. Bernd Koch, director of the artificial kidney unit, and head nurse, Miss Frye, examine a patient's chart. Nurses and doctors on the unit hold frequent informal conferences to deal with day-to-day problems.

have built-in alarms that alert the staff to any sudden change in the system.

The patient also can develop serious problems with little or no warning, such as a sudden fall in blood pressure, severe muscle cramps, nausea and vomiting, or dyspnea and shortness of breath. The nurse must be able to initiate treatment immediately, since there is seldom a doctor in the room.

Ability to work as a member of a small team. Most dialysis units in Canada are still small, with few beds and few nurses. The unit is under the direct supervision of a staff physician, who may or may not have interns and residents working with him. There is usually a head nurse and a varying number of staff nurses. There may be technicians who are responsible for the equipment but who are seldom directly involved in patient care. Less intimately involved with the team are dietitians, social workers, and laboratory technicians.

All these people, with varying backgrounds and responsibilities, must be able to work together efficiently and happily to provide a safe and pleasant atmosphere for the patients – and for themselves! Thus, if a nurse does not like the work or feels unable to cope with it, she would do well to transfer to some other department. Agreement on policies and purposes and close cooperation are essential for a smoothly functioning unit.

Positive, cheerful attitude and emotional maturity. Caring for patients who constantly face serious illness and death is a difficult and demanding task. To deal with chronic dialysis patients, a nurse must first understand her own feelings about the value of the program, about her role in it, and about illness and death. She must be able to offer hope and encouragement, while recognizing that each patient requires a different approach.

Patients often need to talk out their problems and concerns and may use expressions or state ideas that are offensive to those around them. A very real example of this is the attitude of patients who have waited a long time for a transplant. They frequently "joke" about highway accidents, knowing full well that a traffic fatality may produce a donor kidney. The nurse can neither condone nor condemn such comments. And a quiet, cheerful atmosphere gives the patients confidence and helps them to relax and to feel more "normal."

Good health and dependability. Although last on the list, good health is by no means the least important requirement for a dialysis nurse. She is usually one of a small team, as previously mentioned, and if she is absent the others must add her work load to their own. Relief is not available from other sources because of the need for specialized training.

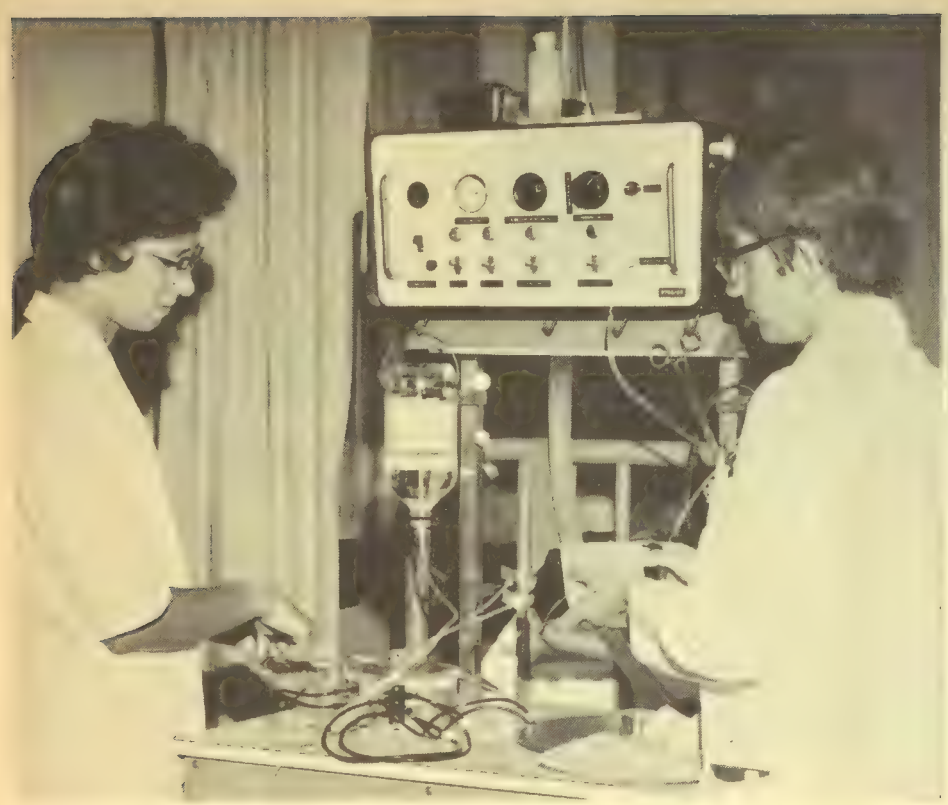
An undependable nurse is never an asset and may become a burden to others. On the other hand, the staff must be aware of certain health hazards encountered in this work, particularly the danger of contracting hepatitis from contact with contaminated blood. Certain precautions are necessary in handling needles and syringes, donor blood packs, and the tubings and membranes of the artificial kidney.

Unless it is run on a 24-hour basis, a dialysis unit must have staff always on call for emergencies. These emergencies include patients with acute renal failure, poisoning, and transplant rejection that requires dialysis. Thus the nurses must be prepared on occasion to work long hours with little relief.

Staff illness also endangers the patient. Uremic patients have little resistance to infection and recover poorly from added illness. Therefore, a nurse with a cold or with skin infections, for example, should avoid contact with these patients or observe reverse precaution technique when near them.

Present trends in dialysis

In April 1969, there were 45 hemodialysis centers in Canada, caring for 284 chronic patients.[1] Many of the smaller centers are planning to expand in the near future, and more hospitals are starting dialysis programs. As in so many medical specialties, there is a continuing need for new, trained personnel. Since most schools of nursing do not include dialysis nursing in their curricula, it is the responsibility of each unit to train its own staff. Some do this with on-the-job, apprentice-type training; other hospitals send their nurses to a larger center, usually in the United States, for more formal training. A committee of the Canadian Society of Extra-Corporeal Circulation Technicians (CanSECT) has been assigned the task of setting up formal training programs in English and in French to provide adequate nursing and technical personnel for Canada's dialysis



Head nurse (right) helps Lynne Patterson, a new nurse in the artificial kidney unit, to hang up a unit of sedimented cells during dialysis. Early in their orientation, new staff learn to set up and monitor the machines and to be responsible for the technical aspects of dialysis.

centers.

The nurse who is interested in research will find many challenges in this field. Many centers are now doing transplantation as well as chronic dialysis, and nephrologists and surgeons are actively involved in transplant evaluation and research. The nurse who is willing to spend the time and effort to gather statistics and to review patient files and professional literature can be a great help to the physician. At the same time she develops new skills and interests of her own, which make her work more interesting and allow her to grow professionally. Her perspectives broaden and she can take a long-range look into the future, rather than dwelling on the day-to-day frustrations and disappointments.

More and more dialysis-oriented literature is appearing in the scientific journals. In addition, professional organizations, such as CanSECT and the Ontario Dialysis Association, have been set up to provide information and service. These will become more active and more influential as hemodialysis and kidney transplantation become more common.

The future of hemodialysis is uncertain. Almost every center operates at capacity and many have patients waiting for openings to go onto the program. Some hospitals are setting up home dialysis programs, where the patient is trained at the center to perform his own dialysis with the help of a relative and his family doctor. A mini-unit is then set up in his home, and the bed space in the hospital becomes available to train another patient. Because of the limitations of space and funds, this may prove the most effective system. Transplantation will become more common and more successful as methods are found to prevent the rejection of the graft. This too will ease the strain on the hospital dialysis center.

Summary

An introduction to hemodialysis nursing has been presented, describing the procedure and outlining certain criteria for the nurses. This is a relatively new specialty in medicine and is expanding rapidly. It provides opportunities that general bedside nursing does not, but at the same time it places many more demands on the nurses. Maclean, Creighton, and Berman summarized the situation in an article written 11 years ago. Chronic dialysis was not being carried out then, but their words express what this writer has tried to say.

"Ideally, the nurse who works on the renal laboratory and artificial kidney unit team should devote her full working time to it. Many more nurses need to be trained for this work .... Only in this way will they gain the familiarity and experience to work with maximum efficiency, competence, speed, and ease as team members. While the hours may be long and somewhat uncertain ... there is a very real satisfaction in the work."[2]

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Parents participate in care of the hospitalized child

A study conducted at The Hospital for Sick Children in Toronto shows that the amount of care a parent is willing to give the hospitalized child depends on the age of the child, the nurses' attitude toward the parents' help, and whether or not the parents were born in Canada.

E. Mae MacDonald

Recently an immigrant mother whose son was a patient at The Hospital for Sick Children, Toronto, was heard to say, "When my other boy had operation here five years ago, he cry every time I leave. This boy no cry. For him I wash, feed, bandage. He no cry. I like better." This is the kind of conversation you hear as you walk down some of the corridors of the hospital.

Four years ago, members of the hospital staff realized that parents could share in the care of their children. To allow this, visiting time was increased from four hours each afternoon to nine hours daily, from 11:00 a.m. to 8:00 p.m.

The question then was, "What can parents do to help?" There were other questions we wanted answered: What did nurses believe the parents could do for their children? What did parents believe they were capable of doing? What were the differences of opinion between nurses and parents? Was there any difference in the response of Canadian-born parents and foreign-born parents? How did the age of the child affect the amount of parental care offered?

To find the answers, we conducted a study in which we interviewed and observed 76 parents whose children had been admitted to the cardiac, neurosurgical, and ear, nose, and throat units; to the general surgical wards, including orthopedic, urological, and plastic surgery; and to units where children were isolated because of burns and surgical infections. Fifty of these parents were Canadian-born; 26 were born outside Canada. Of the latter, 11 had lived in Canada less than 10 years.

We hoped that our findings would encourage the staff to accept the help of parents and to realize that the parent is the key to continuity in the child's care.

Mrs. MacDonald, a graduate of the Atkinson School of Nursing, Toronto Western Hospital, was Assistant Surgical Coordinator of family-centered care at The Hospital For Sick Children, Toronto, at the time of writing.

Methods used

To make sure the nursing staff understood the study, I explained its purposes and methods to the head nurses and asked for their suggestions on family care of the child in hospital. In conferences with ward staff members, I encouraged their cooperation and invited their opinions.

I chose the parents for the study at random. When I first met them, I explained the background and purpose of the study, and how they could help. Although they wished to help, many parents believed their contribution would be limited. As soon as parents agreed to participate, I notified the nurses who were caring for the children involved.

The information gathered from the parents included whether the child had been in hospital before, and if so, where;



the father's occupation; where the family lived; whether the mother worked outside the home; how often the parents could visit the child; the number and ages of brothers and sisters; whether the parents had ever been patients in hospital; what they did when they visited their child; and whether they knew how long their child might be in hospital.

Nurses and parents answered questionnaires, stating what the parents would be willing and able to do for their child and what assistance they would require. I summarized the nurses' and parents' answers and recorded relevant suggestions.

Finally, I observed what the parents did for their child when they visited; the attitude of the nurse toward the parents; what the nurse thought about the parents' help; and how much the nurse encouraged the parents to do for their child.

Parent participation varies

Of the 76 questionnaires completed by the parents, 62 (81 percent) were answered by the mother alone; 2 (3 percent) were answered by the father alone; and 12 (16 percent) were answered by both parents. Seventy-one nurses replied to the questionnaire. Five did not answer it because they believed they did not know the parents well enough.

All parents said they would comfort their child. Over 90 percent agreed to encourage their child to drink, to help feed him, to undress him on admission, and to entertain or play with him.

Canadian-born parents were more willing to help care for their child than parents born outside Canada. At least 10 percent more Canadian-born parents were willing to take the child's temperature, pulse, respirations, and blood pressure, feed or bathe him in a croupette, go with him to x-ray, and make his bed.

Parents born outside Canada, but residing here for more than 10 years, appeared less willing to participate in the care of the child than parents who had lived here less than 10 years. This was particularly true when this care involved disciplining the child; taking his temperature, pulse, and respirations; feeding or bathing him while an intravenous was running or while he was in a croupette; going with him to the operating room; obtaining a urine specimen and keeping a record of elimination; and making his bed.

The activities in which parents living in Canada less than 10 years would participate were mainly those of a mothering or protective nature, such as setting limits on the child's behavior, encouraging him to drink fluids, undressing him on admission, feeding or bathing him with an intravenous running or while he was in a croupette, holding him for the doctor's examination, going with him to x-ray, and giving him oral medications.

A few nurses thought that parents who had resided in Canada less than 10 years could help more. When parents and child shared another language, nurses left more of the care to the parents. During the study some nurses did not talk to the parents if they believed, often incorrectly, that they did not speak English.

Parents and nurses disagree

Nurses and parents differed in their opinion on the care parents could give their child. Of 320 disagreements that arose between parents and nurses, 2.2 percent occurred with parents of children up to the age of 23 months; 40.3 percent in the two-to-five-year-old group; 34.4 percent in the six-to-10-year-old group; and 23.1 percent with parents of children 11 years and older.

Most parents were willing to help more than nurses were willing to let them, particularly with suctioning; percussing the chest to facilitate drainage; changing dressings; taking blood pressure, temperature, pulse, and respiration; and restraining the child during painful procedures.

The investigation showed that nurses usually accepted help offered by parents, and that the nurses believed parents of children under five would do more for their child if encouraged to do so. However, although parents and nurses agreed that these parents could do more in their child's care, they disagreed on what duties the parents of children under five



At The Hospital for Sick Children in Toronto, parents are encouraged to help the nurses in the care of their children. These photographs show a mother helping her child who is on a Stryker frame.

could share. Parents of six- to 10-year-olds were more reluctant to undertake the tasks that parents of the younger children were willing to do, except restraining the child when necessary.

More parents of children in all age groups were willing to give oral medications than nurses were willing to let them. More nurses than parents thought parents could feed or bathe a child in a croupette in all groups except 11 years and older. More parents, except those of six- to 10-year-olds, wished to help feed their child, bathe him even when intravenous was running, take him to the operating room, and set limits to his behavior.

Information collected on surgical wards showed that a high percentage of parents and nurses disagreed on the parents' ability and willingness to change dressings. Parents were not as willing to change dressings as might be expected, considering that many of them would have to change these dressings at home. A few said they did not want to see their child's recent wound. However, more parents were willing to change dressings than were nurses willing to allow them to carry out this procedure.

Disciplining the child caused disagreement among parents and nurses. Some parents said the hospital was no place to discipline a child, and others disciplined their child only if his behavior concerned them directly. Nurses sometimes were reluctant to set limits for the child because of possible reproach from parents. A few nurses thought some parents were too anxious and doting to discipline the child.

More than one mother said she would not make the child's bed or take him to the toilet because the child saw this as the nurse's function. Occasionally a child would say: "The nurse is supposed to do that," or "I want my nurse to help me." Some parents said they would not make the child's bed because they would be unable to make the bed the way the nurse did.

Results of Study

Findings of this study are being used in a pilot project, and results will be assessed again in another year.

The most notable result of the study is a more positive attitude toward parent participation that has developed among the nurses, showing they are aware of the need for the parent to maintain ties with the child.

The study shows that most parents seem unaware of the effect of separation on the child and the effect of their participation in his hospital care. Hospital staff perhaps could discuss this in community-parent organizations.

The nurses learned from parents who added touches of warmth, bringing photographs of the family or pets, or leaving a precious treasure. One mother brought an old clock, which never did run. Sometimes a mother helped her child write letters to his friends or thank-you notes for gifts. Often she shared her attention with other children who had no visitors.

Some nurses are still hesitant about parent participation. Recently, however, one nurse said: "At first I was skeptical about the study. I thought it would increase and complicate our work – and sometimes it does. But it is so much more gratifying to nurse the child who is secure because his parents share his care." Another nurse said, "It gives me the opportunity to learn more about family influences on my patient and to understand his reaction to being in hospital. Having the parents here is a great advantage for teaching child health. I feel I am really nursing." □

Drug adverse reaction program — and the nurse's role

The Canadian drug adverse reaction program is unique in that it depends on members of all health professions for its effectiveness.

E. Napke, M.D.

Early in 1965 the Food and Drug Directorate of the Department of National Health and Welfare initiated a program designed to collect and evaluate reports of suspected drug adverse reactions.* The prime intent of the program was to develop some method and alerting system that would detect or prevent another thalidomide tragedy.

From the beginning, this program incorporated the concept that all members of the medical and paramedical team should participate in the program; otherwise it would be ineffective. This approach is contrary to that used in other countries, which usually depends on only the medical profession for the reporting of adverse drug reactions.

The drug adverse reaction reporting program consists of two systems: the "drug alert system" and the "evaluation and research system." The drug alert system, which is probably the key to drug surveillance, is devised to warn or alert personnel of possible problem areas of suspected drug adverse reactions. The evaluation and research system is designed to investigate specific problems identified in the drug alert system by retrospective and prospective techniques.

Six aspects of the Canadian drug adverse reaction program make it unique: 1. our definition of a drug adverse reaction; 2. formulation or trade-name orientation; 3. pigeon-hole alert system; 4. involvement of the whole parameter of personnel in the medical team, from the physician to the nurse, including pharmacists, dentists, and veterinarians; 5. development of a food adverse reaction program; and 6. a tie-in with the poison control program — in other words, the program can pick up information on the interplay between chemicals and humans with special emphasis on those chemicals known as drugs.

As soon as a problem area is identified, the next steps are automatic.

The key to the problem of drug adverse reactions is to know when a *suspected* drug adverse reaction actually becomes a drug adverse reaction. This is a difficult problem to solve. Other than using the "rechallenge procedure," which involves giving the suspected drug again after a reaction and getting the same response, most other methods of approaching the problem are by guess and opinion. This is especially true in the case of a single reported incident. Obviously, the opinion becomes stronger and more certain as the number of incidents increase.

A drug adverse reaction may result from a combination of the suspected drug and the diet or disease, or other chemicals and drugs. In these cases, however, the likelihood of one person seeing such a combination often enough to reinforce a suspected reaction is small. If, however, a

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*An adverse drug reaction is defined as any action or lack of action that is not of therapeutic, diagnostic, or prophylactic benefit to the patient.

number of observers have similar suspicions of adverse reactions to a specific drug or formulation, the chances of suspecting a reaction are greatly increased.

Basic to the alert system is the simple, easy-to-complete Food and Drug 123 series of reporting forms and the more complicated F&D 122 form. (See *Figure I* for sample of F&D 123 form) The F&D 123 was specifically designed to be as simple as possible to encourage the reporting of suspicions by medical practitioners and paramedical personnel. This form is distributed periodically to doctors, dentists, veterinarians, coroners, pharmacists, and some nurses.

To gather data to show cause-and-effect relationship in each specific case of suspected drug reaction would be costly and time-consuming and would require highly-trained personnel and adequate facilities. However, the Canadian drug adverse reaction reporting program does pick up trends and, epidemiologically, may show a cause-and-effect relationship when dealing with large numbers of reports.

It is considered medically wise and scientific for the physician to be aware of the adverse reactions to any drug he prescribes and to know the severity and frequency of these reactions. Only then is he in a position to equate the safety-therapeutic equation. The safety-therapeutic equation is usually defined as the equation that balances the known degree of safety of a drug against its therapeutic benefit for a patient.

At present we do not know how common the common reactions are, or whether "common" in Halifax is the same as "common" in Vancouver, either in type of reaction or frequency. It is important for us to know how common the common reactions are and whether these reactions are increasing or decreasing. If they *are* increasing or decreasing, we should know why.

This is one reason why we are collecting all cases of suspected and proven drug adverse reactions, whether common or otherwise, to all drugs, new and old. We must know how common "common" is!

Chronic drug adverse reactions

Up to this point, most participants in the program are concerned primarily with acute drug adverse reactions. Chronic reactions are also important and data must be collected on them. Is there an early warning symptom, such as rash or headache, that heralds a full-blown disease one, two, or ten years later? Individually, members of the healing professions would be lost in this type of data study. However, if everyone contributes to the study, the problem may be solved more easily.

Sometimes a flash of insight occurs to an observer, but the next case with a similar situation may not appear for some months, so the original flash of insight is forgotten. However, if, at the time, the suspected reaction is reported, the likelihood of matching with similar reactions is greatly increased. It is in the interest of the patient, medical and paramedical professions, and pharmaceutical industry that all suspicions of drug adverse reactions are reported.

In addition to the alert system described, we are now developing an alert system based on computerized programs. The difficulties we have encountered are not unique; a number of other countries have been computerizing their data for a number of years and are still in various degrees of development.

Examples of recent adverse reactions

Up to now we have talked about *suspected* drug adverse reactions and have defined adverse reaction. However this does not really describe the chain of events that leads to recognition of a drug adverse reaction. The following are two recent examples of the simplicity and complexity of a drug adverse reaction.

Recently, reports came from New Zealand and Australia about the drug diphenylhydantoin sodium. It was observed that a number of patients were showing signs of toxicity or overdosage of diphenylhydantoin. On investigation it turned out that an excipient** in the formulation had been replaced by another excipient – a sugar. It now turns out that this substitution increased the rate of absorption and perhaps the amount of the active ingredient – diphenylhydantoin – absorbed. This resulted in the patient receiving a toxic dose although, as far as the prescribing doctor was concerned, the patient was still being given what the physician considered a therapeutic dose of the active ingredient.

Of course the classic example is that of the monoamine oxidase inhibitors (MAO). These drugs were used to elevate the mood in various depressions.

Several years ago, letters to the editor appeared in the British medical journals, first associating the monoamine oxidase inhibitors with severe headaches, hypertension, and cerebrovascular accidents. The letters then began to indicate that in addition to the monoamine oxidase inhibitors, certain types of cheese were also involved.

Laboratory analysis of certain aged cheese showed that they contained pressor amines and that it was the combination of the monoamine oxidase inhibitors and cheese containing pressor amines that resulted in headaches and occasional cerebrovascular accidents. It was not long

IN CONFIDENCE

To:
Drug Adverse Reaction Program
Food and Drug Directorate
Tunney's Pasture, Ottawa

For FDD use

*NOTIFICATION OF SUSPECTED OR PROVEN ADVERSE EFFECTS OF DRUGS
*INCLUDING SIDE EFFECTS, TOXICITY, IDIOSYNCRASY, INTOLERANCE, ALLERGY, INCOMPATIBILITY ETC

SUSPECTED DRUG (Trade Name) (Including vaccine, anti-sera, etc.)

Date drug administered approx

Date onset of reaction

Route and daily dosage

Suspected reaction (Including allergic, anaphylactic, etc.)

(brief description of suspected toxic side effects, frequency and dates if possible)

Please use reverse side for concomitant therapy and comments

If no other drugs used please state.

Age, sex, height and weight of patient

Patient's name or initials

From:
Name

Street

City Prov.

Signed Date

F & D 123 (R 67)

**An excipient is defined in *Dorland's Medical Dictionary* as: any more or less inert substance added to a prescription in order to confer a suitable consistency or form to the drug.



Dr. E. Napke, Medical Officer in Charge of the federal government's Drug Adverse Reaction and Poison Control Program.

after this that certain wines, pickled herring, chicken livers, and certain cold remedies were found to contain pressor amines in amounts to account for the symptoms described.

Another type of reaction involved alcoholic patients and tolbutamide. It was found that tolbutamide is metabolized faster in alcoholic persons than in non-alcoholics. Thus, there is a need for more specific control of the alcoholic patient.

How many more chemicals are there whose therapeutic value is modified by the state of the patient, who might be alcoholic, addicted, or a chronic smoker?

Then, again, several chronic diseases are often treated concomitantly, so a patient may be receiving tolbutamide for one condition and receiving phenylbutazone for another. Unfortunately, it was found that somewhere and somehow inside the body these two chemicals interreact, resulting in an increased hypoglycemic response to tolbutamide. Hence the diabetic patient is out of control.

The list is ever increasing. The first example was that of a drug adverse reaction resulting from a formulation change; the second, an interreaction between a drug and a food; the third, a drug and the state of the patient; and the fourth, an interreaction resulting from specific therapy for two different diseases within the same patient. The problem will continue as each new chemical is added to the environment of man.

Who discovers drug adverse reactions?

The first suspicion can come from any source – nurse, physician, pharmacist, nutritionist, veterinarian, or layman. Unfortunately, some time may elapse before a definite cause-and-effect relationship is proven.

The role of the physician in the reporting of cases of suspected drug adverse reactions is evident. The pharmacist can make two major contributions:

1. He is possibly the only person who has any knowledge of the sale, distribution, and medical complaints concerning over-the-counter products and is in a good position to ascertain whether the patient is receiving drugs from a number of physicians, or is self-medicating. This type of situation is complicated, but he should be able to report to us his suspicions following the complaints of some of his customers. Also, he can relate his suspicions to the prescribing physician.

2. The role of the hospital pharmacist is dictated by the policy of the hospital concerned. The pharmacist is in a unique position to tabulate and collate the amount and types of drugs prescribed for any one patient, not only in the hospital setting but also in the outpatient department. In other words, he is aware of the flow of drugs in and out of the hospital as well as the specific patients involved with these drugs.

The role of the veterinarian is unique. Often identical drugs are used to treat animals and man for diseases that are similar as well as dissimilar. Because these drugs may be used in a more heroic manner in animals than in man, the veterinarian can often pick up suspected drug adverse reactions early.

Often a large number of animals are treated at one time; this can lead to good epidemiological evidence for cause-and-effect relationships between the particular product, the animal, and the disease.

Role of the nurse

The previous outline gives some of the background, philosophy, and hardware of the system as well as the role played by the nurses' coworkers in the reporting of suspected adverse drug reactions. What, then, is the role of the nurse?

The nurse is in a position to play an important role, whether she works in the physician's office or on the hospital ward. She should take note of each prescription change and find out why the change was made. Was it because of some adverse reaction, such as a rash, diarrhea, hiccups, loss of appetite, change in personality, failure of the drug to live up to its therapeutic claims? Or was there some other reason? She should then ask the physician in charge whether she should send a report to the pharmacy and therapeutics committee in the hospital. Sometimes the physician may wish to make the report himself. In this case the nurse can remind the physician at the time of the patient's release from hospital.

Often the first signs or symptoms of a drug adverse reaction are noted in the nurse's reports, only to be overlooked by the physician. A system should be set up in hospitals to investigate nurses' suspicions of drug reactions. The occurrence of a rash does not always mean that the penicillin administered to the patient caused it. On the contrary, it could be due to any other drug given singly or in combination, as well as the usual differential diagnosis for a rash. Drugs, excipients, foods, fluids, and so on, are all chemicals and can act with or in replacement of the chemicals of the body on each other.

The nurse must be alert to suspected drug adverse reactions. The hospital nurse, in particular, should keep in mind the possibility of drug adverse reactions with any "happening" that does not go with a particular patient and his disease. These "happenings" can include: 1. a change in signs or symptoms; 2. the onset of new signs and symptoms; 3. laboratory findings; 4. psychic changes and fetal abnormalities.

The most obvious "happenings" are personality and mood changes, changes in level of consciousness, skin changes, changes in appetite and gastrointestinal function, facial changes, and deviation from the normal sleep pattern, energy, and so on. The nurse informs the physician of any change and then asks whether he should forward the report of the suspected adverse reaction. These reports usually are sent to the pharmacy and therapeutics committee of the hospital, but if there is not such a committee, either the nurse or the physician should report directly to the Food and Drug Directorate in Ottawa. It is hoped that the pharmacy and therapeutics committees will forward *all* reports that they receive to us.

Reports received are all reviewed at the Food and Drug Directorate and coded. Then they are readied for a possible *alert* concerning that particular drug.

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research abstracts

Tissington, F. Claire. *An exploratory study of the relationship between physical and social-psychological distance and nurse-patient verbal interaction.* Montreal, 1969. Thesis (M.Sc.(App.)), McGill University.

An exploratory study of the relationship between physical and social-psychological distance and nurse-patient verbal interaction was carried out on the maternity ward of a 265-bed general hospital. Data was collected in 100 observations of nursery nurses interacting with mothers during the infant feeding period. The observer used interaction and physical distance check lists to record observations. Nurses completed questionnaires designed to measure their perception of individual patients.

Findings indicated that the amount of the nurse's verbal interaction was related to the nurse's perception of the patient and the patient's days postpartum, parity, method of infant feeding, age, socio-economic status, and nationality. Results suggest implications for patient-assignment and parent and nursing education, as well as areas for further research.

Joseph, Mary. *Effectiveness of clinical instructors as perceived by nursing students.* London, Ont., 1968. Thesis (M.Sc.N.) U. of Western Ontario.

While evaluation of students is practiced continuously in most educational programs, teacher evaluation is given little consideration in many areas. This study was designed to determine the effectiveness of teachers in promoting the learning of nursing students in the clinical area of a hospital as perceived by their students.

A total of 11 instructors from two university schools of nursing, one in Ontario and the othe; in Quebec, was rated by nursing students of the four-year baccalaureate program. A rating scale for clinical instruction, fashioned after the Purdue rating scale for instruction, was used in obtaining student ratings and it included 10 items from the Purdue rating scale for instruction. A pilot study demonstrated the usability of the rating scale for clinical instruction.

Wide variations were seen in the results of individual teachers rated irrespective of their age, educational background and experience. Mean average of ratings on each item was computed for schools A and B. A definite correlation was observed between the rankings of the mean averages of schools A and B on items one to 16 but a significant difference was noticed between the two rankings for items 17 to 30. The item which scored the highest mean average for both the schools was concern for patients' welfare, and that which scored the lowest mean average was presentation of subject matter. Interest in subject, personal appearance, and knowledge of nursing practice were the next items which scored higher mean averages. Items such as fairness in grading, liberal and progressive attitude, sense of proportion and humor, personal characteristics, stimulating intellectual curiosity, and counselling scored comparatively lower mean averages.

The concept of teacher effectiveness and the importance of teacher evaluation are explored. Possible conclusions and implications from the literature and from this study, which might bear on the practice of teacher evaluation and improvement of instruction in nursing education are drawn. Certain ideas evolved from the study for future research are suggested.

Perry, Susan. *Relationship between attitude and person-centeredness of nursing care* Boston, 1969. Thesis (M.Sc.N.) Boston University.

This study was undertaken to identify the relationship between nurses' attitudes toward physically disabled persons and the person-centeredness of their responses to patients with a specific physical disability.

The sample consisted of 30 registered nurses employed on surgical units in two large general hospitals. The study tools were a standardized attitudinal scale, attitude toward disabled persons (ATDP) and a modification of the response to patient inventory. The inventory consisted of 15 simulated nurse-patient interaction situations in which a female patient who recently had a mastectomy directed a statement or question to the nurse. The interaction situations were sub-divided into three categories according to the type of feeling expressed by the patient in the situation. The nurses' written responses were categorized along a continuum from person-centered, to person-positive, to neutral, to non-person-centered.

There was a significant relationship between the nurses' attitude toward physically disabled persons and the person-centeredness of their responses to the patients. The Spearman's coefficient of rank order correlation between the two scales was .65. The respondents were consistent in their responses regardless of the type of feeling expressed by the patient. The nurses gave person-positive responses most frequently. Most of the respondents gave a disproportionately large number of person-positive responses to situations in which the patient expressed feelings of conflict or irritations over enforced dependency or submission. Situations in which the patient expressed feelings of danger for her self-regard, self-esteem, or standing in the eyes of significant others elicited the greatest number of negative responses. The nurses responded most positively to situations in which the patient expressed feelings of danger for her survival. The differences in the responses to the three categories of situations were related largely to the type of feeling being expressed rather than to the attitude of the respondents to physically disabled persons.

MacLeod, Ella, and Gill, Sister Catherine. *A study of the needs of graduates from two year diploma nursing programmes in Canada.* Boston, 1968. Thesis (M.Sc.N.) Boston U.

The primary purpose of this study was to gain some insight and knowledge into the needs of graduates from two-year diploma nursing programs in the first three months of employment. An attempt was made to determine the graduates' needs specifically in the performance of nursing and management skills, as general staff nurses. The basis for justification of the study was an awareness that nursing service personnel should be prepared to meet the needs of these graduates when first employed.

The review of literature revealed a trend toward shortened diploma nursing programs in Canada. Though many articles have been written and studies done on graduates of shortened programs in the United States, the investigators found only a limited number of studies on graduates from Canadian programs. In view of the trend toward shortened programs, it was thought advantageous to conduct further research in this area.

A questionnaire was structured to elicit the amount of guidance 25 selected graduates required in the performance of certain nursing and management skills during the first three months of employ-

ment. Data were also obtained to determine the graduates' ability to transfer knowledge of principles and meet emergencies, and to determine their speed and dexterity in carrying out nursing procedures.

This questionnaire survey cannot be considered a completely valid evaluative tool because of the many intervening variables. The most significant was the length of time that elapsed between the end of the third month of employment and the time the head nurses completed the questionnaires. The results of the study, however, do reveal some significant information regarding the amount of guidance the graduates required for specific skills.

The findings in the section marked "unknown," gave cause for considerable reflection. One wonders why there was such a high percentage of activities about which the head nurses were ignorant of the amount of guidance the graduates needed. These unknown areas could contain specific needs that were not revealed in the study.

The analysis of data revealed that two-thirds of the nurses required the most guidance in management skills related to indirect care of the patients. The skills with which the nurses needed the most guidance were: organizing activities on 3-11 shift, establishing priorities in giving nursing care, interpreting doctors' orders, and assuming the role of team leader.

It was of interest to note that out of 25 nurses, only 3, or 12 percent, had not had charge responsibilities on the 3-11 shift, or had not had experience as team leaders. This would seem to indicate that, at least in the hospitals employing the nurses studied, the graduates of two-year diploma programs are expected to assume the role of team leader and are assigned to the 3-11 shift within the first three months of employment.

Additional information obtained from the study suggested that the nurses needed help in the application of theory to practice. This would seem to be a normal need of a young practitioner in any field. These nurses also exhibited another characteristic common to most young practitioners: they were slow in completing a workload. The study also revealed that over 50 percent of the nurses required help in meeting emergencies.

MacKay, Ruth C. *Effects of interpersonal difference, social distance, and social environment on the relationship between professionals and their clientele.* Lexington, 1969. Thesis (Ph.D.) U. of Kentucky.

People in the helping professions must invariably depend upon interpersonal communication with their patients or clients if they are to render appropriate assistance, and social distance is a crucial element in this communication process. It is the thesis of this study that social distance in professional-client relationships is determined by norms in the social situation and by psychological variables associated with the personalities of both the professional and the client or patient. Some social distance is assumed to be functional in supporting the asymmetric relationship typical of and necessary to the helping professions. On the other hand, too much distance may hamper the relationship, obstructing the professional's assessment of the client's or patient's condition, or impeding the rehabilitative process.

Nine determinants of social distance are examined in the nurse-patient relationship, as one example of professional-client relationships. Differences in age, sex, race, and social class between nurses and patients were studied as sociocultural factors. In addition, humanitarianism, professional motivation, and opinionation (the chosen personality variables) were measured in the nurse population. The nurse-patient relationship was studied both in a hospital and in an outpatient clinic to determine the effects of environmental variables; and the influence of time and duration was controlled by limiting the study to the first meeting of nurse and patient and to the taking of a nursing history.

The study population consisted of nursing students three months from graduation in a collegiate nursing program and regularly admitted patients in a university medical center. Transcripts of 37 taped interviews provided the data for measuring social distance and effectiveness of communication. Race had to be deleted from the study as only five suitable Negro patients were available. Multiple correlation analysis failed to indicate any significant correlations between differences in age and in social class, humanitarianism, opinionation, or professional motivation. However, sex differences correlated moderately and in some instances markedly with social distance and with effectiveness of communication. There are also distinct differences in social distance and effectiveness of communication between the hospital and the clinic setting. In particular, social distance was greater and the effectiveness of communication less with opposite-sex participants in hospital, but in the clinic the findings were reversed. In addition, the length of the interview, which ranged to a maximum given limit of 30 minutes, correlated inversely with social distance and positively with the effectiveness of communication.

Two explanations of the sex difference findings are offered. It is possible that the nurses (all female) in general relate better to males than to females, and it is the awkward and intimate encounter with hospitalized males who are in bed that masks the more fundamental preference female nurses demonstrate for males. Secondly, it may be that the nurses usually relate more closely to hospitalized patients since they have been more fully socialized into the role of the nurse in the hospital than in other treatment environments, and it is the socially devalued dependency of hospitalized males that creates the reversal of findings in the hospital situation.

Pringle, Dorothy M. *The use of a conceptual model to evaluate psychiatric nursing therapy.* Colorado, 1968. Thesis (M.S.) Univ. of Colorado.

This study was designed to construct a conceptual model for short-term psychiatric nursing therapy to help the nurse systematically identify and evaluate her work with patients. Three central questions were examined in the study, namely: 1. What are the strengths and limitations of the model? 2. Is the model helpful in identifying the phases and process of nursing therapy? 3. Is the model useful in evaluating the nurse's work with patients?

A methodological research approach was used in the study. The investigator worked with three patients in a mental health clinic. A conceptual model was developed by the investigator to examine systematically her work with these patients.

This model, which was constructed through the process of study and revision and under the guidance of a specialist in psychiatric nursing therapy, has three main phases of therapy, namely, the initiating phase, the intensive treatment phase, the concluding phase, and 10 sub-phases. Selected principles of cybernetics and concepts of short-term psychotherapy were used as a conceptual framework in developing the model. After the model was developed, it was independently tested by three clinical specialists in psychiatric nursing in relation to the three questions stated above. The specialists analyzed 21 hours of nursing therapy by classifying the content of the therapy into specific categories.

The major findings of the study were that the model had many strengths, including a high percent of reliability when used by different analysts; an appropriate sequence of phases and sub-phases; and it was easy to use. The limitations of the model revealed a need for definitions of the categories and other minor factors that were easily corrected by a revision. The model was especially helpful in identifying the phases and process of therapy. It was useful in evaluating how systematically the nurse was working with the patient, and helped to identify areas in which there was concentration or in which there were omissions. □



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books

Intensive Nursing Care by Zeb L. Burrell, and Lenette Owens Burrell. 298 pages. Saint Louis, Mosby. 1969.
Reviewed by Maureen Bennett, Head Nurse, Intensive Care Unit, The Montreal General Hospital, Montreal, P.Q.

Nursing the intensive care patient requires wide knowledge of medical conditions that lead to the patient becoming critically ill. On many intensive care units, inservice education for nurses has been introduced to help staff assimilate this knowledge more quickly and to understand treatments more intelligently.

This book is compiled from lectures given by medical staff to nursing personnel who work in an intensive care unit.

The book's strength lies in its clear organization of subject matter. There are sections on anatomy, physiology, pathology, and therapy of common conditions afflicting each organ system. Familiar problems of congestive heart failure and pulmonary emboli, as well as the rare addisonian crisis and thyroid storm are discussed.

One serious omission is that of 'shock'; nowhere is it treated as a distinct entity, although it is the most common reason for a patient's presence in an intensive care unit. Also, the widespread advocated use of prophylactic antibiotics and anticoagulants needs to be clarified.

Although some techniques limited to larger centers – open heart surgery, hemodialysis, emergency and elective surgery in pulmonary embolus, and treatment of severe burns – are omitted, this book is well worth reading by nursing staff of small hospitals and teaching centers.

Associate Degree Nursing: A Guide to Program and Curriculum Development by Ann N. Zeitz, Leila D. Howard, Elva M. Christy and Harriette Simington Tax. 207 pages. Saint Louis, Mosby, 1969.
Reviewed by Joyce Nevitt, Director, School of Nursing, Memorial University of Newfoundland, St. John's, Newfoundland.

Rarely does one find so comprehensive an approach to nursing education in so few pages. This book fulfills the purpose stated in the preface in lucid and concise language. Not only does it provide a guide to those who are planning two-year programs in nursing in Canada, but it could serve as a stimulus to experienced teachers who are seeking new approaches to teaching nursing *as a process* in any program in nursing.

New teachers would welcome the guides to planning preparation. Various methods and tools of teaching are illustrated with examples based on sound rationale.

A chapter that discusses interpersonal relationships within and outside the college, and between faculty and students, could serve as a basis for new teachers in their orientation to their role in the college.

The concept of a core curriculum is well illustrated. The philosophy and rationale of each part of the curriculum clearly show how the authors conceptualize coordination of the total program. Learning experiences, including specific readings and audiovisual aids, are described. These are preceded by specific objectives and concepts for each unit. Day-by-day projections of nursing content and experiences and samples of student assignments, including evaluation forms, follow each unit.

The authors suggested five approaches to nursing education. This is an example of the flexibility of the book as a guide to teachers. Adaptations can be made according to the particular orientation of the teacher, without losing sight of the objectives of the total program. The scientific and humanistic principles learned in related courses are noted. Preventive aspects of health are included throughout, particularly with respect to community health, nutrition, and mental health and mental illness. A separate chapter deals with mental health and mental illness as an aid to identifying the objectives and learning experiences. Reference readings are timely and pertinent to each unit.

Discussion of the teacher's dress may be considered irrelevant, but new teachers may appreciate reading different arguments on what the teacher should wear in the clinical area.

The book reinforces a coordinated, total concept of nursing. The curriculum is planned to teach *nursing*, not *hospital* nursing. This book, however, is only a guide and its value will depend on the quality of the teachers who use it.

The author of the text *Essentials of Nursing* 2nd ed. (Toronto, W.B. Saunders Company, 1969), which was reviewed in the November 1969 issue, is Claire Brackman Keane.

Nurses Technical Manual 1968-69 by W.E. Broome, 100 pages. London, Butterworth & Co., 1968. Canadian Agent: Butterworth & Co. (Canada) Ltd., Toronto.
Reviewed by J.M. Dawes, Director of Nursing, Prince George Regional Hospital, Prince George, B.C.

This soft-cover, well-illustrated, concise manual published in Great Britain is intended to familiarize nurses with the types and uses of hospital equipment currently available. Some of the material is organized in relation to systems, (e.g. respiratory, digestive). The clinical notes interspersed throughout help the reader understand the basic principles of application of the equipment discussed.

A section devoted to diagnostic procedures gives the indications for such tests and the normal range of values. Equipment used in the prevention of cross infection, and in drainage and suction is also discussed. A comprehensive bibliography is included.

This manual would be a valuable reference to nurses in Great Britain, but its usefulness to Canadian nurses is questionable. Much of the equipment discussed is not used on this continent or is known by another name, although the diagrams may help the reader to identify the counterparts in use here. The color coding of gas cylinders is different than that used in Canada and could, therefore, be dangerously misleading. There are variations in the normal results of diagnostic tests from those given in "Clinical Laboratory Procedures" in *The Canadian Nurse* (Feb. 1969).

It is this reviewer's opinion that the manual is, at best, of limited value to nurses practicing in Canada.

Toohey Medicine for Nurses, edited by Arnold Bloom 9th ed. Edinburgh, E.& S. Livingstone Ltd., 1969. Distributed by Macmillan Co. of Canada Ltd., Toronto.
Reviewed by Myrna Sherrard, Nurse Clinician, The Moncton Hospital, Moncton, New Brunswick.

(Continued on page 49)


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books

(Continued from page 47)

The basic facts needed to understand the nature and treatment of most of the medical diseases that the nurse may encounter are presented clearly and concisely in this text.

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One chapter discusses important drugs: their actions, uses, dosage, and toxic effects. At the end of the book there is a comprehensive list of all drugs mentioned, their approved or chemical names, trades names, and action on diseases in which they are used.

There is an interesting chapter on psychological medicine. The author considers topics such as the psychological development of the individual, psychosomatic medicine, the psychological effects of illness, and the psychological role of the nurse.

Although the sections on obesity, drug addiction, and organ transplantation are brief, sufficient valuable information is presented to make inclusion of these topics worthwhile.

There is a section that includes points to remember on subjects such as the patient as an individual, the nursing of elderly patients, rest, noise, and the problem of the bedpan, diet, and smoking.

Throughout the text there are over 200 illustrations, colored photographs, and original diagrams that help the reader understand and remember some of the more important facts.

This is a valuable reference book for students and graduate nurses. It is easy to read and should be understood without difficulty. □

accession list

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plus recognition for postgraduate experience. Shift differential. Apply to: Matron, Tofino General Hospital, Tofino, Vancouver Island, B.C.

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REGISTERED NURSE for Doctor's office. Please send application with references and information regarding age, experience and expected salary to: Hanover Medical Clinic, Box 640, Steinbach, Manitoba.

NOVA SCOTIA

GENERAL DUTY NURSES: Positions available for Registered Qualified General Duty Nurses for 138-bed active treatment hospital. Residence accommodation available. Applications and enquiries will be received by: Director of Nursing, Blanchard-Fraser Memorial Hospital, Kentville, Nova Scotia.

ONTARIO

TEACHERS for September 1970. Regional School program for classes of sixty students. Teach patient-centered nursing in both clinical and classroom setting. University preparation essential. For school brochure and application forms write to: Director, Algoma Regional School of Nursing, 150 Conmee Avenue, Sault Ste. Marie, Ontario.

FACULTY: Positions available January 1970 in maternal-child or maternity and pediatric nursing areas for new baccalaureate program. Master's degree in clinical specialty required. Rank and salary commensurate with qualifications. Calendar year appointment. Apply to: Dean, School of Nursing, Queen's University, Kingston, Ontario, Canada.

REGISTERED NURSES for 34-bed General Hospital. Salary $460 per month to 550 plus experience allowance. Residence accommodation available. Excellent personnel policies. Apply to: Superintendent, Englehart & District Hospital Inc., Englehart, Ontario.

REGISTERED NURSES needed for 81-bed general hospital in bilingual community of Northern Ontario R.N.'s starting salary — $500/m., with allowance for past experience, 4 weeks vacation, 18 sick leave days. Unused sick leave days paid at 100 percent every year. Master rotation in effect. Rooming accommodation available in town. Excellent personnel policies. Apply to: Personnel Director, Notre-Dame Hospital, P.O. Box 850, Hearst, Ont.

REGISTERED NURSES. Applications and enquiries are invited for general duty positions on the staff of the Manitouwadge General Hospital. Excellent salary and fringe benefits. Liberal policies regarding accommodation and vacation. Modern well-equipped 33-bed hospital in new mining town, about 250-mi. east of Port Arthur and north-west of White River, Ontario. Pop. 3,500. Nurses' residence comprises individual self-contained apts. Apply, stating qualifications, experience, age, marital status, phone number, etc. to the Administrator, General Hospital, Manitouwadge, Ontario. Phone: 826-3251.

REGISTERED NURSES required for the Nipigon District Memorial Hospital. New 37-bed hospital opened on March 26, 1969. Attractive salary and fringe benefits. Residence accommodation available at $50 a month. For further information, write to: Mrs. G. Gordon, Superintendent, Nipigon, Ontario.

ONTARIO

REGISTERED NURSES for a 100-bed General Hospital, situated 40 miles from Ottawa. Excellent personnel policies. Residence accommodation available. Apply to: Director of Nursing, Smiths Falls Public Hospital, Smiths Falls, Ontario.

REGISTERED NURSES REQUIRED IMMEDIATELY FOR 53-BED HOSPITAL. STARTING SALARY $485. Three weeks vacation, pension plan, life and medical insurance, 9 statutory holidays, 40-hour week. Air, rail and road facilities. Northern hospitality. Apply to: Director of Nurses, Porcupine General Hospital, South Porcupine, Ontario.

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REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS for 160-bed accredited hospital. Starting salary $485 and $340 respectively with regular annual increments for both. Excellent personnel policies. Residence accommodation available. Apply to: Director of Nursing, Kirkland and District Hospital, Kirkland Lake, Ontario.

Registered Nurses Urgently Required for General Staff — In 63-bed modern hospital in Western Ontario situated near Sarnia and the American border. Basic salary for 1969, $470. per month with annual increments, shift differential and allowance for past experience. Residence accommodation available at the present time. Apply: Director of Nursing, Charlotte Eleanor Englehart Hospital, Petrolia, Ontario.

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ONTARIO

Nurses with I.C.U. training, O.R. training and experience, and general duty nursing. Wanted for 80-bed General Hospital recently enlarged, located in summer and winter sport area. Apply: Director of Nursing, Huntsville District Memorial Hospital, Box 1150, Huntsville, Ontario.

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UNITED STATES

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ANNOUNCEMENT

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UNITED STATES

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To be responsible for administration and management of operating room nursing service.

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SASKATOON, Saskatchewan

UNITED STATES

Director of Nursing Services, University of Washington, University Hospital, 1959 N.E. Pacific Avenue, Seattle, Washington, 98105.

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— Duties to commence approximately August, 1970
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The Director of Nursing
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Salary commensurate with qualifications and experience.

Apply to:

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Duties: To conduct the employment relations activities of the Association, promote the development of staff nurses' associations, coordinate their activities and act as liaison between their associations and promote and facilitate communication among professional nurses in the Province.

Qualifications: A minimum of a Bachelor's degree in nursing. Over two years specific work experience or four to eight years related work experience. A theoretical knowledge of nursing plus a practical working knowledge of industrial relations. Must be free to travel extensively throughout the Province.

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Obtain applications from the
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Desirable qualifications should include B.S.N. Degree with experience in supervision.

For further information,

Write to:

Director of Nursing
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Selkirk College, in Castlegar, British Columbia, requires a full-time Director for a two-year Registered Nurses' Training Programme, scheduled to begin in September, 1971.

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EFFECTIVE DATE OF APPOINTMENT:

July 1, 1970.

SALARY:

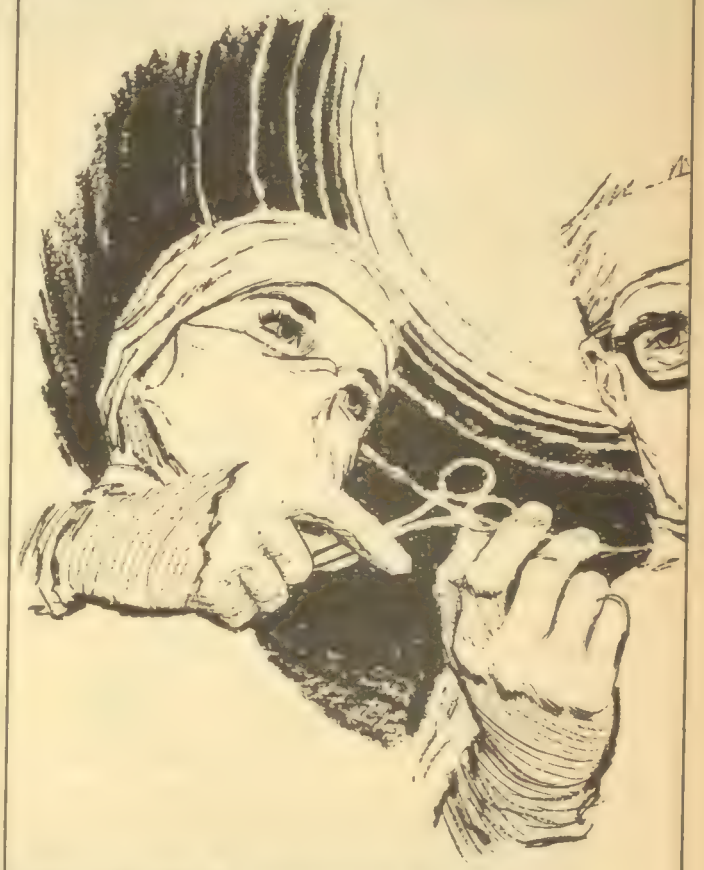
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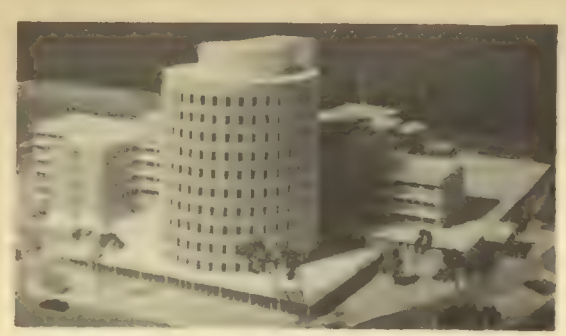
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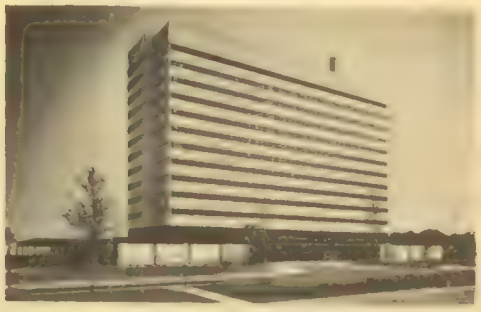
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Anne H. Rohweder, M.N., discusses this timely question in the December **Nursing Clinics of North America,** in one of seventeen vital articles. Among the others are "Nursing Care of the Cardiac Surgery Patient," by Barbara Rogoz, M.S.N., and "Staffing and Staff Relations in Coronary Care Units," by Catherine A. Baden, B.S.N.Ad., and Jacquelyn A. Huebsch, B.S. Each of the seventeen articles is written especially for the Nursing Clinics by a leading authority, and each illuminates a specific facet of the subject of a symposium. The two symposia in the forthcoming December issue are: "Care of the Cardiac Patient," with Adeline C. Jenkins, R.N., as Guest Editor, and "Compassion and Communication in Nursing," with Grace Theresa Gould, M.S., as Guest Editor.

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Edited by WALDO E. NELSON, M.D., D.Sc., R. JAMES McKAY, M.D., and VICTOR C. VAUGHAN III, M.D.. 1590 pages, 527 illustrations, 26 in full color. $23.25. Ninth edition published August, 1969.

Singer & Singer: Psychological Development in Children

Instead of merely describing what children are like at various ages, this new text emphasizes the processes of development and presents a unified theory.

By ROBERT D. SINGER, Ph.D., and ANNE SINGER, 437 pages, illustrated. $8.65. Just ready. Published October, 1969.

Jablonski: Dictionary of Eponymic Syndromes

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By STANLEY JABLONSKI. 335 pages with 126 illustrations. About $13.80. Just ready.

Morgan & Engel: The Clinical Approach to the Patient

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By WILLIAM L. MORGAN, Jr., M.D., and GEORGE L. ENGEL, M.D. 314 pages, illustrated. $10.55. Published May, 1969.

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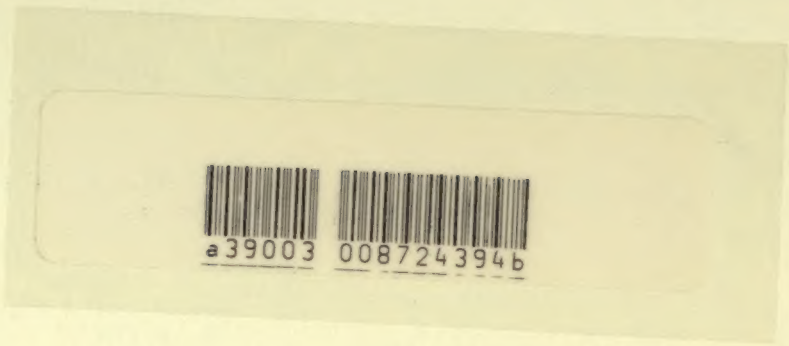
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